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HUMAN RIGHTS AND SCIENTIFIC AND TECHNOLOGICAL DEVELOPMENTS

Guidelines, principles and guarantees for the protection of persons detained on grounds of mental ill-health or suffering from mental disorder

Report by the Rapporteur: Mrs. Erica-Irene Daes

A contribution to (a) the protection of the human and legal rights of persons who are mentally ill or suffering from mental disorder; (b) the abolition of psychiatric abuse; and, (c) the promotion of mental health law.

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INTRODUCTION

1. In its resolution XI of 12 May 1968, on human rights and scientific and technological developments, the International Conference on Human Rights recommended that the organizations of the United Nations family should undertake a study of the problems with respect to human rights arising from developments in science and technology.

2. By its resolution 10 A (XXXIII) of 11 March 1977 on human rights and scientific and technological developments the Commission on Human Rights requested the Sub-Commission to study, with a view to formulating guidelines, if possible, the question of the protection of those detained on the grounds of mental ill-health against treatment that may adversely affect the human personality and its physical and intellectual integrity. In 1979, the Sub-Commission requested the Secretary-General to prepare a report on the subject with a view to the formulation of guidelines relating to the medical measures that may properly be employed in the treatment of persons detained on the grounds of mental ill-health and procedures for determining whether adequate grounds exist for detaining such persons and applying such medical measures (resolution 6 (XXXII) of 5 September 1979).

3. The General Assembly, by its resolution 33/53 of 14 December 1979, requested the Commission on Human Rights to urge that the study of the question of the protection of those detained on the grounds of mental ill-health be undertaken as a matter of priority by the Sub-Commission.

4. At its thirty-third session in 1980 the Sub-Commission, by its resolution 11 (XXXIII) of 10 September 1980, having considered the report submitted by the Secretary-General pursuant to Sub-Commission resolution 6 (XXXII) (E/CN.4/Sub.2/446), entrusted the Rapporteur with the task of preparing "guidelines related to procedures for determining whether adequate grounds exist for detaining persons on the grounds of mental ill-health, and principles for the protection, in general, of persons suffering from mental disorder". The General Assembly at its thirty-fifth session welcomed the action taken by the Sub-Commission to implement General Assembly resolution 33/53 (resolution 35/130 B of 11 December 1980).

5. At its thirty-fourth session in 1981, the Sub-Commission had before it a preliminary report by the Rapporteur (E/CN.4/Sub.2/474), which contained, pursuant to Sub-Commission resolution 11 (XXXIII), in an annex, a questionnaire. At the Rapporteur's request, the questionnaire was transmitted by the Secretary-General for comments to Governments, specialized agencies, regional intergovernmental organizations and non-governmental organizations concerned. As of 27 July 1981, as stated in the Rapporteur's preliminary report (E/CN.4/Sub.2/474), comments had been received from a number of Governments, specialized agencies, regional intergovernmental organizations and non-governmental organizations.

6. A written statement was also submitted to the Sub-Commission at its thirty-fourth session by the International Association of Penal Law and the International Commission of Jurists (E/CN.4/Sub.2/NGO/85).

7. By its resolution 20 (XXXIV) of 10 September 1981, the Sub-Commission, having considered the preliminary report, requested the Rapporteur to submit her final report, including a draft body of (a) guidelines related to procedures for determining whether adequate reasons exist for detaining persons on the grounds of mental ill-health or mental disorder, (b) principles for the treatment and protection, in general, of persons suffering from mental disorder, and (c) guarantees for the protection of the human rights of persons suffering from mental disorder, to the Sub-Commission at its thirty-fifth session. By the same resolution, the Sub-Commission also decided to establish at its thirty-fifth session a sessional working group to consider the body of guidelines, principles and guarantees with a view to adopting it at its thirty-fifth session.

8. At its thirty-sixth session in 1981, the General Assembly, by its resolution 36/56 B of 25 November 1981, noted with satisfaction the work undertaken by the Sub-Commission on the question of the protection of those detained on grounds of mental ill-health and requested the Commission to continue its consideration of this question in the light of the action taken by the Sub-Commission, with a view to submitting a report to the General Assembly at its thirty-eighth session through the Economic and Social Council.

9. The Commission on Human Rights at its thirty-eighth session in 1982 noted with appreciation the preliminary report by Mrs. Daes and decided to consider the final report at its thirty-ninth session (Commission resolution 1982/6 of 19 February 1982). By the same resolution, the Commission expressed its conviction that "detention of persons in mental institutions on account of their political views or on other non-medical grounds is a violation of their human rights".

10. In accordance with Sub-Commission resolution 20 (XXXIV), the questionnaire prepared pursuant to resolution 11 (XXXIII) of the Sub-Commission was, by note verbale of 14 November 1981, transmitted to all Governments to which it had not yet been transmitted, and a reminder was also sent to those Governments, specialized agencies and non-governmental organizations concerned which had not yet complied with the previous request addressed to them.

11. As of 16 July 1982, substantive comments have been received from the Governments of 45 States: Afghanistan, Australia, Austria, Bahamas, Barbados, Belgium, Bulgaria, Burma, Cameroon, Canada, Chile, Colombia, Costa Rica, Cyprus, Denmark, Dominican Republic, Finland, France, Germany (Federal Republic of), Greece, Italy, Japan, Jordan, Korea (Republic of), Kuwait, Madagascar, Mauritius, Netherlands, New Zealand, Niger, Philippines, Portugal, Senegal, South Africa, Spain, St. Vincent and the Grenadines, Sweden, Syrian Arab Republic, Thailand, Ukrainian SSR, Union of Soviet Socialist Republics, United Kingdom, United States of America, Upper Volta, Zimbabwe.

12. Comments were also received from the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organizations and the United Nations Children's Fund, as well as from the United Nations Centre for Social Development and Humanitarian Affairs (Social Affairs Officer Crime Prevention and Criminal Justice Branch).

13. As concerns the position of the World Health Organization with respect to the present study, the Rapporteur wishes to note that this specialized agency has also provided some preliminary comments and information through correspondence between it and the Division of Human Rights. 1/ These comments and information, as well as certain additional data and recommendations which the Rapporteur selected from relevant World Health Organization publications, have been taken into consideration by her in elaborating the present report. Any further information from the World Health Organization will be taken into account when the Rapporteur revises her report. Replies to the questionnaire were also received from the Council of Europe and the Organization of American States.

1/ Which has been redesignated a Centre for Human Rights as from 29 July 1982.

14. The following non-governmental organizations also sent substantive information: American Psychiatric Association, American Psychological Association, Amnesty International, Commission Suisse pour la Protection des Droits de l'Homme contre les Abus Psychiatriques, Commonwealth Medical Association, Council for Science and Society, International Association of Democratic Lawyers, International Association of Penal Law in co-operation with the International Commission of Jurists, International Federation of Human Rights, International Human Rights Law Group, Rehabilitation International, World Council of Churches, World Federation of Mental Health, World Medical Association, World Federation of Neurology, World Federation of Neurosurgical Societies, World Psychiatric Association. Also replies were received from the National Association for Mental Health "MIND" and the Comité National Suisse de la Santé Mentale.

15. In accordance with the mandate given to her by resolution 11 (XXXIII) of the Sub-Commission, the Rapporteur has taken into account, in the preparation of the present report, in addition to comments by Governments, specialized agencies, regional intergovernmental organizations and non-governmental organizations concerned, all kinds of relevant available material. She was therefore confronted with the difficult task of studying an enormous amount of documentation. This task was rendered even more difficult by pressure of time and shortage of resources as well as United Nations regulations on the limitation of documentation. For this reason, it has been impossible to discuss in detail all aspects of the topic of mental illness and its related problems and to reflect in this document extensive information on these matters.

16. As suggested in her preliminary report (E/CN.4/Sub.2/474 of 3 August 1981) and her relevant introductory statement before the Sub-Commission, 2/ the Rapporteur is submitting in the present document a chapter containing a concise review of the topic of mental illness and the protection of persons who are mentally ill or suffering from mental disorder; and a draft body of guidelines, principles and guarantees which is submitted particularly for consideration first in the sessional Working Group of the Sub-Commission to be established in accordance with Sub-Commission resolution 20 (XXXIV); and secondly by the plenary of the Sub-Commission. The draft body of guidelines, principles and guarantees as contained in this report is mainly based on the relevant debates which took place in the General Assembly, the Commission on Human Rights and the Sub-Commission, the replies received which have been analytically compiled and on reliable material selected by the Rapporteur.

2/ A summary of this introductory statement appears in the summary records of the 916th meeting of the Sub-Commission (E/CN.4/Sub.2/SR.916).

I. A CONCISE REVIEW OF THE TOPIC OF MENTAL ILLNESS AND MENTAL DISORDER AND THE PROTECTION OF PERSONS WHO ARE MENTALLY ILL OR SUFFERING FROM MENTAL DISORDER 3/

(a) Background and scope of the topic

17. The key question how to protect more effectively persons diagnosed as suffering from mental ill health or mental disorder is an extremely acute, urgent and important one for the international and national communities. Also, the inevitable medical, legal, political, social, economic, cultural and, in certain cases, religious problems related to it are of exceptional complexity.

18. "Mental illness" as a serious and dangerous phenomenon caused by the gods, or resulting from luna has been known from time immemorial. In the sixteenth century, when the first "psychiatry revolution" occurred, mental illness was recognized as something other than the possession of the patient by the devil. 4/

19. In the nineteenth century the idea of mental institutions was implemented.

20. Certain States started to build rurally or semi-rurally located institutions for the treatment of patients.

21. These institutions were known as "asylums". Their establishment was a kind of response to the conditions of disorder in great cities caused by industrialization of the nineteenth century.

22. The basic common characteristics of the asylums of that period were the inhuman living conditions and the cruel, even brutal, treatment of the patients.

23. At that time, procedures for the admission of patients to the asylums were easier than those for their discharge.

24. The length of stay in asylums, and in the more modern mental hospitals which were subsequently established was reduced between the years 1919 and 1940, although an increase of readmissions could be in certain cases observed.

25. After the Second World War and until 1949 there was no substantial improvement in mental hospitals or in the treatment of the patients, despite the adoption of certain modern national Constitutions and of the first human rights instruments at regional and international level.

26. In the year 1950 the so-called drug revolution took place. New and powerful tranquillizing drugs were introduced and offered for more effective, active therapy for various psychotic illnesses than had been previously available. 5/ Also, certain forms of "minor" tranquillizers were developed. Nevertheless, some criticism of "excessive" use of such drugs was expressed.

3/ In this report the term "patient" covers the terms "the mentally ill" and "persons suffering from mental disorder".

4/ See G. Zilboarg, A History of Medical Psychology, (Norton, New York, 1941).

5/ For more details, see W.J. Curran and T.W. Harding, The Law and Mental Health: Harmonizing Objectives (World Health Organization, Geneva, 1978), p.15.

27. Fundamental changes in the fields of political history, economic progress, protection of human rights and advances in the treatment, hospitalization and rehabilitation of patients took place in the years 1955-1970.

28. One of the most striking developments from the political, economic, social cultural, legal standpoints was the wave of independence among a great number of nations of the least developed world. The legal structures set up in the years of colonialism were continued in matters related to health, including mental health legislation. Methods, medical and psychiatric practice, the treatment of the patients and large mental hospitals were based on the patterns of the colonial times.

29. Also notable changes took place in the treatment of the patients, including, as has already been mentioned, an effective drug treatment. The importance of the social environment of patients was recognized and "social therapy" and a pragmatic approach to the assessment of therapy was evolved.

30. Unfortunately, very little has been done in connection with public mental hospitals which, in most countries, are not adequately funded by the State. They have gross deficiencies, especially in medical and nursing personnel, poor food and unsatisfactory relationships between the medical personnel and the patients.

31. The main explanation of these unsatisfactory conditions of mental hospitals in many countries is that the maintenance of high standards in public mental health institutions is not always among the high priorities of Governments. Governmental reluctance in a great number of developed countries - or inability in certain least developed countries - adequately to fund mental hospitals has often brought the care, treatment and accommodation conditions of patients below acceptable human civilized standards.

32. In many cases the failure of the State to establish proper community facilities pushes former patients into non-psychiatrically oriented institutions, mainly nursing homes.

33. This fact and these situations have led certain writers to raise the issue of "deinstitutionalization" as a means of ensuring better and more human standards of care and treatment for patients.

The protection of the human rights of the patient and scientific and technological development

34. The Charter of the United Nations, in its Articles 13 and 62, provides that the General Assembly, the Economic and Social Council and their subsidiary bodies may make or initiate studies and reports with respect to international economic, social, cultural, educational, health and related matters, and may make recommendations with respect to any such matters to the General Assembly, to the Members of the United Nations, and to the specialized agencies concerned. In particular, the Economic and Social Council and its subsidiary bodies may also "make recommendations for the purpose of promoting respect for, and observance of, human rights and fundamental freedoms for all".

35. The Universal Declaration in which the people of the United Nations reaffirm their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights for men and women, contains in its articles 3, 5, 6, 7, 8, 9, 10, 12, 25, 26, basic provisions related to the protection of the human rights of the patient.

36. The International Covenant on Civil and Political Rights, in its article 7 prohibits torture and cruel, inhuman or degrading treatment or punishment, and states "in particular, no one shall be subjected without his free consent to medical or scientific experimentation".

37. Despite the above-mentioned basic provisions, and other clauses and recommendations contained in other international instruments, which are relevant to some aspects of the effect of scientific and technological development upon the enjoyment of human rights and fundamental freedoms, this question was not considered in detail until 1968, when it was discussed by the International Conference on Human Rights.

38. Paragraph 18 of the Proclamation of Teheran provides: "While recent scientific discoveries and technological advances have opened vast prospects for economic, social and cultural progress, such developments may nevertheless endanger the rights and freedoms of individuals and will require continuing attention". 6/

39. The International Conference on Human Rights dealt with the question of human rights and scientific and technological developments at greater length in its resolution XI by which it recommended that the organizations of the United Nations family should undertake a study of the problems with respect to human rights arising from developments in science and technology. 6A/

40. Since then the General Assembly and the Commission on Human Rights have adopted a great number of resolutions 7/ on the question of human rights and scientific and technological developments and, in recent years, to the protection of the human rights of patients. 8/

41. The Declaration on the Use of Scientific and Technological Progress in the Interests of Peace and for the Benefit of Mankind, 9/ also contains basic provisions which expressly state: (a) that scientific and technological achievements can entail dangers for the civil and political rights of the individual or the groups and for human dignity; and (b) that all States shall take appropriate measures to prevent the use of scientific and technological developments, particularly by the State organs, to limit or interfere with the enjoyment of the human rights and fundamental freedoms of the individual as enshrined in the Universal Declaration of Human Rights, the International Covenants on Human Rights and other relevant international instruments. 10/

6/ Final Act of the International Conference on Human Rights (United Nations publication, Sales No. E.68.XIV.2), p.3.

6A/ Ibid., p.12.

7/ See the introduction to the present report, pp.3-5.

8/ See the Preliminary report by the Special Rapporteur, Mrs. E.I. Daes, (E/CN.4/Sub.2/474) of 3 August 1981, pp.1-2.

9/ Proclaimed by the General Assembly of the United Nations on 10 November 1975 (resolution 3384 (XXX)). See Human Rights - A Compilation of International Instruments (United Nations publication, Sales No. E.78.XIV.2), pp.125-126.

10/ Preambular paragraph 4 and paragraph 2 of the Declaration on the Use of Scientific and Technological Progress in the Interests of Peace and for the Benefit of Mankind, ibid., p.125.

42. The impact of recent scientific and technological developments on the right to health, and in particular on problems related to mental disorders caused by the urban environment and experiments on human subjects, and the meaning of "informed consent" for the purpose of such experiments, were discussed in detail at the Seminar on human rights and scientific and technological developments. 11/

43. The World Health Organization (WHO) has made a great contribution, in particular through its studies and publications, to the protection of the human rights of persons suffering from mental disorder, and to informing the world community of the health aspects of avoidable maltreatment of prisoners and detainees and of the effects of psychiatric treatment on prisoners. 12/

44. The work done by the World Health Organization on apartheid and mental care, deserves particular attention. In a preliminary review the WHO presents, inter alia, in a summary the following serious allegations which were made about privately provided institutions accommodating many thousands of mentally ill black Africans detained there against their will: 13/

(a) The institutions, run by a private enterprise known as Smith Mitchell and Company, keep in custody an exceedingly large number of Africans, admitted on an involuntary basis through a perfunctory legal and medical procedure;

(b) The standards of care provided and the living conditions of the patients in these institutions are extremely poor and degrading, not only in comparison with the standards of mental health care ensured for the white population, but also in relation to the most elementary and essential human needs and rights;

(c) There is a collusion of interest between the private companies and the State, in the sense that the companies are making profit using Government subsidies, while the Government is spending through this arrangement less than it would have to if mental health care for Africans were to be provided entirely by the State health services;

(d) The chain of private institutions for mentally ill black Africans is a tool for human rights oppression and racial discrimination in the field of health care under the apartheid system. 14/

11/ See the Report of the Seminar, which was held in Vienna, Austria, 19 June - 1 July 1972, (ST/TAO/HR/44), paras. 43-44.

12/ See, among others, T.W. Harding and W.J. Curran, Advances in the Drug Therapy of Mental Illness (World Health Organization, Geneva, 1976); "Promoting Mental Health Through the Law", WHO chronicle, 32:10-113 (1978); the paper on "Health Aspects of Avoidable Maltreatment of Prisoners and Detainees" prepared by WHO and presented to the Fifth United Nations Congress on the Prevention of Crime and the Treatment of Offenders (Toronto, Canada 1-12 September 1975) (A/CONF.56/9); and W.J. Curran and T.W. Harding, The Law and Mental Health: Harmonizing Objectives (World Health Organization, Geneva, 1978).

13/ In the years 1974-1975, reports in the South African press exposed the existence of a chain of privately-owned institutions in which many thousands of mentally ill black Africans were detained against their will.

14/ See "Apartheid and Mental Health Care", in Objective: Justice, (United Nations Office of Public Information), 9:1, Spring 1977, p.37.

45. The Chairman of the United Nations Special Committee against Apartheid requested the World Health Organization to undertake an enquiry into these allegations and to consider appropriate measures that WHO might take.

46. On 13 May 1976, the Minister of Health of the Republic of South Africa issued a press statement concerning what he called the "international campaign against the mental health services" and accused a particular religious group of spreading "propaganda" and "unadulterated nonsense" about the South African mental health services. In the same statement, the Minister extended an "open invitation" to the Director-General of WHO "to visit personally, together with any other person or persons whom he may wish to accompany him, any institution or institutions in the Republic,to acquaint himself with the prevailing conditions".

47. This invitation to the Director-General of WHO was issued only a few weeks after the South African Parliament assented to an amendment to the Mental Health Act of 1973. This amendment outlaws the publication "in any manner whatsoever" of "false information concerning the detention, treatment, behaviour or experience in any institution of any patient or any person who was a patient, or concerning the administration of any institution". The amendment also prohibits the taking and publication of photographs or sketches of any mental institutions and of mental patients by persons who are not members of the Newspaper Press Union of South Africa or have not been authorized by the Secretary of State.

48. In response to the request of the United Nations Special Committee against Apartheid, and in view of the serious implications of the Mental Health Amendment Act of 1976 for the feasibility of an open and free discussion in situ, the Director-General of WHO decided to undertake the present preliminary inquiry into the mental health situation in the Republic of South Africa, and, in particular, into the allegations about discrimination, inhuman treatment and exploitation of black mental patients. The inquiry was based mainly on published official South African documents, scientific publications, and consultations with experts. Being a response to the specific request of the Chairman of the Special Committee against Apartheid, the inquiry is at the same time part of an ongoing WHO study on the health and psychosocial implications of apartheid.

49. The information and comments of the author of the aforesaid preliminary review done by the World Health Organization are the following: "Between 8,000 and 9,000 Africans suffering from mental disorders are detained against their will in privately owned institutions in the Republic of South Africa. These Africans are the object of a business deal between the State and profit-making white-owned companies which receive Government subsidy on a per capita basis against the provision of custodial care for mental patients, who are referred to in Government publications as the 'sediment of mentally maladjusted persons and deviates'. There is not a single black psychiatrist in South Africa and vital decisions about thousands of African mental patients are made by part-time physicians who do not even speak the language of the patients. While the majority of the white mental patients are receiving care in services provided by the State (the provision of psychiatric beds per 1,000 of the white population is 3.3 times greater than for Africans), the majority of the African mental patients are certified as mentally ill by the State and transferred involuntarily to profit-making private 'sanatoria'. About one-third of the whole mental health budget of the Republic of South Africa subsidizes this operation. The rapidly rising 'demand' for institutional care of the mentally ill Africans, which is given as an explanation of these anomalies and discriminatory practices, is understandable in the context of over-all apartheid policies which have resulted in the uprooting of over three million people, the disintegration on a mass scale of the African family and the breakdown of community support for the mentally ill. Recent legislative measures of the Government concerning the 'rehabilitation' of

African pass offenders equate in a dangerous way the non-observance of the apartheid laws with mental disorder. The Mental Health Amendment Act of 1976 virtually imposes a ban on information and free discussion of the prevailing conditions and policies in the mental health services. These conditions and policies, being a direct effect of apartheid in the health field, are inimical to the letter and spirit of the Constitution of the World Health Organization which proclaims that the 'enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'". 15/

50. The World Health Organization has already examined the implications of the doctrines of apartheid in South Africa, with the basic conclusion that "the prevailing situation stemming from the policy of apartheid presents an obstacle to the achievement of the highest level of health for all individuals". 16/

51. It is evident that the implications of apartheid for the mental health of the population and for mental health care cannot be understood if taken out of the context of the psychosocial stress and deprivations which are inherent by design in contemporary South African society.

52. "Apartheid is a crime against humanity" and inhuman acts resulting from the policies and practices of apartheid and similar policies and practices of racial segregation and discrimination, as defined in article II of the International Convention on the Suppression and Punishment of the Crime of Apartheid, are crimes violating the principles of international law, in particular the purposes and principles of the Charter of the United Nations and constituting a serious threat to international peace and security". 17/

53. The Rapporteur on another occasion has written that the Government of South Africa set out on the path to apartheid as the frightened response of a white minority to the challenge of democracy in a multiracial State with an overwhelming black majority. 18/ Thus one of the main consequences of this abhorrent system is the almost total control over the lives of men and women through legislation that is based on racial distinctions.

54. Consequently, millions of people in South Africa are being exposed to stress undercutting at the roots of their experience of dignity, security and purpose in life. Typical stresses affecting all these millions of people and creating for the African an environment characterized by unpredictability, hostility and inhuman acts include, inter alia, the following:

(a) Forced mass uprooting. Under the legislation aiming to achieve a "bantustanization" in certain desert places of the country by forcing against their will millions of black people into the so-called "homelands";

15/ Ibid., p.37.

16/ See Objective: Justice, vol. 7, No.2, p.37.

17/ Articles I and II of the International Convention on the Suppression and Punishment of the Crime of Apartheid, in Human Rights: A Compilation of International Instruments, (United Nations publication, Sales No. E/78.XIV.2), pp.30-33. See also, the study of the Special Rapporteur, Mrs. E.I. Daes, "The Duties of the Individual to the Community and the Limitations on Human Rights and Freedoms under article 29 of the Universal Declaration of Human Rights", Part I, paras.74-78.

18/ See E.I. Daes, "Protection of Minorities under the International Bill of Human Rights and the Genocide Convention" in Xenion: Festschrift für Pan. J. Kapos, (Athens, Ch. Katsicalis, 1973), vol. II, p.55, note 53.

(b) Forced splitting of families. The overriding purpose of the "homelands" programme is to perpetuate white economic and political supremacy through creating a mobile pool of destitute migratory labour. Africans are thereby declared aliens in their own country and compelled to spend most of their active lives as migrant workers in white-controlled areas. African men return to their families, who are confined in the "homelands", only once or twice a year. Family life is severely disrupted or non-existent;

(c) Enforced economic deprivation and unfavourable discrimination on salaries and wages;

(d) Enforced inferior status and de-individuation. This is the result of a series of laws and practices: e.g. the Population Registration Act of 1950, which set up a racial register of the population and whose implementation required a "reclassification" of about 1 per cent of the total population of the country; the Bantu Education Act of 1953, whose basic objective was to eliminate "the vain hope that was created among the Natives that they could occupy posts within the European community"; 19/

(e) Harassment and basic insecurity. The great number of unfair and discriminatory laws to which the black Africans are subjected creates for them serious problems of threat to their freedom and insecurity. For example, section 29 of the Bantu Urban Areas Act contains detailed definitions of "idle" and "undesirable" Africans;

(f) A Cultural "double-bind" situation. The cultural heritage of the African people is defamed as "ignorance, traditional taboos and superstition" by the white minority;

(g) Denial of means of self-expression and coping with stress. Black Africans are deprived of most of the mechanisms which human groups employ to cope with situations of frustration, tension and stress.

55. A high number of blacks in South Africa die in police detention, many of them on the day of their arrest. For example, 92 people died in police detention in 1975, of whom 16 were mental patients, and out of the 92 deaths, 23 were due to suicide.

56. Mental health care for black Africans is a seriously neglected area in the Republic of South Africa, despite the vast economic resources of the country.

57. It should be also noted that in the reply of the Republic of South Africa to the questionnaire sent out in connection with the present study not one of the above-mentioned elements is mentioned. 20/ This reply provides general information concerning (a) the definition of "mental illness" and "psychopathic disorder", etc., (b) statistics which indicate that the number of in-patients decreased between the years 1975 and 1980, (c) types of mental institutions, clinics, (d) procedures for determining whether adequate grounds exist for detaining persons on the grounds of mental disorder, (e) treatment of minors, (f) safeguards, (g) principles for protection of persons suffering from mental disorder, (h) protection of legal rights/status, (i) procedures in criminal proceedings, (j) medical treatment, and (k) rehabilitation.

19/ See: A preliminary review by the World Health Organization on Apartheid and Mental Care, in Objective: Justice (United Nations Office of Public Information), 9:1, Spring 1977, p.39.

20/ See the reply of the Government of the Republic of South Africa, submitted on 30 July 1981, in the annex to the present report.

58. Although the aforementioned reply could be considered as a general complete reply to questionnaire on this study, it has been criticized on the basis of hiding information related to legislative and administrative measures in force in the country concerning, in particular, living conditions, discrimination, the policy and the practice of apartheid in connection with black people suffering from mental ill health or mental disorder, their treatment and the types of the hospitals or the places in which they are detained.

International Labour Office

59. The International Labour Office (ILO) is not normally concerned with the matters relating to the protection of persons suffering from mental disorder. However, the Committee of Association of the ILO Governing Body has considered a case in which allegations were made of anti-union action by means, inter alia, of internment of trade unionists in psychiatric institutions. 21/

United Nations Children's Fund

60. The United Nations Children's Fund considers as an important issue the elaboration of guidelines and principles affecting persons suffering from mental disorder particularly with reference to children or "persons under age" or "minors as referred to in the questionnaire on the present study". 22/

21/ In connection with this case the Committee of Association of the ILO Governing Bodies "also note that a large number of the founders of SMOT - as was also the case of the 'Workers' Free Trade Union Association' - have been, or remain, admitted to psychiatric hospitals or clinics. It would also appear from the elements in the possession of the Committee that certain of these measures were taken against the SMOT founders shortly after the announcement of the foundation of the organization. The Committee must generally stress in this connection that all the necessary safeguards should be provided to prevent such measures from being taken as sanctions or as means of pressure against persons who wish to establish a new organization independent of the existing trade union structure. It would be highly desirable for the Government to re-examine the situation from this point of view".

The Committee's recommendations: "In these circumstances the Committee recommends the Governing Body to approve the following conclusions: As regards the case as a whole, the Committee points out that the right of workers to establish organizations of their own choosing, guaranteed by Article 2 of Convention No. 87, implies in particular the real possibility of forming, in a climate of full security, workers' organizations independent both of those which exist already and of any political party. Regarding the specific legislative question, the Committee recalls that the Committee of Experts on the Application of Conventions and Recommendations considered it desirable that the legislation be amended in order to recognize clearly the right of workers to establish, should they so wish, an organization outside the factory, works and local trade union committees which exist. As for the measures of repression taken against the founders or members of SMOT, the Committee points out on the one hand, that the granting of freedom to a trade unionist on the condition that he leaves the country cannot be considered to be compatible with the exercise of trade union rights. The Committee also points out that all the necessary safeguards should be provided to prevent measures of commitment to psychiatric hospitals from being taken as sanctions or as means of pressure against persons who wish to establish a new organization independent of the existing trade union structure and it invites the Government to re-examine the situation from this point of view". The Committee's recommendations were approved by the Governing body. See the reply of ILO, submitted on 5 June 1981 and the 207th Report (March 1981), paras.129 and 130 of the Committee on Freedom of Association of the ILO Governing Body, (GB.215/9/5, Geneva, 3-6 March 1981).

22/ See the reply of UNICEF, submitted on 5 June 1981, in the annex to the present report.

61. In this connection the following points seem to warrant consideration:

(a) Prevention of mental illness particularly with regard to children, as it is in childhood that prevention must start if it is to be effective. This calls for sound community-based mental health programmes with emphasis on prevention, and with the active participation of local residents in the planning, implementation and monitoring of preventive programmes;

(b) Promotion of health education which needs to include mental health education and recognize at the same time that the subject of mental health is taboo in many countries because of ignorance, prejudice and fear. Hence the added importance of incorporating mental health aspects in all health education programmes;

(c) Development of services which include the whole gamut of prevention, rehabilitation and treatment of the mentally ill. Legislation is often needed for the establishment as well as the funding of these services. Children have special needs which call for special services. These too have to be mandated by law;

Due process of law to ensure that no one is committed to a mental health institution who does not need that type of placement;

(d) Education in keeping with the abilities of the child and worked out with parental participation;

(e) Attention to social factors and recognition that emotional and behavioural disturbances stem from social and economic deprivation and social stress - much of it the result of modernization - all of which tend to erode the social fabric, the family system and the traditionally valued ways of life. The establishment of supports within the family and the community are essential elements in preventing the onset of emotional illness;

(f) Emergencies. UNICEF involvement in emergencies in Africa and in Kampuchea has taught us how the vulnerability of certain population segments such as the mentally ill, and in particular the mentally-ill child or the child at risk, tends to make for greater disorientation than would be the case in "normal" circumstances. It is therefore all the more important to ensure that the rights of the mentally ill are protected not only in day to day life but also in times of emergency (natural disasters, war, refugee upheavals).

62. Consequently, the main point which the UNICEF brings out refers to the rights of the child or the adult before he or she becomes a patient. Hence the importance of the preventive aspects and the need to incorporate them in the legislation, together with appropriate funding allocations. This is in addition to the full range of services available for mentally-ill persons which are provided not only through medical and psychiatric auspices but also through community-based programmes, trained social workers and psychologists. The involvement of close family members is crucial in any decision which affects treatment and placement of a mentally-ill person. The voice of advocacy on these issues needs to be raised loud and clear.

63. Basically, what seems indicated is that the mentally-ill child (or adult) should benefit from the same services provided to the handicapped child (or adult) in terms of prevention, early identification, treatment and rehabilitation that is individually tailored and undertaken in the least restrictive setting, with periodic review of the treatment plan and the applicability of the setting. 23/

23/ See the reply of the UNICEF, p.2.

Regional organizations

Council of Europe

64. The Council of Europe 24/ have paid particular attention to the legal protection of mentally-ill persons. Thus on 8 October 1977 the Parliamentary Assembly of the Council of Europe adopted Recommendation 818 (1977) 24a/ on the situation of the mentally ill. In this Recommendation several problems of internment and civil incapacity of mentally ill persons were raised and a number of points were recommended for the improvement of the situation of these sick persons and to curb abuses of such internments, which are condemned in all democratic societies.

65. The Committee of Ministers submitted this Recommendation to the European Committee on Legal Co-operation (CDCJ) for opinion. The CDCJ at its 30th Meeting (4th as a Steering Committee) proposed to the Committee of Ministers that it change the new Committee of Experts on Legal Problems in the medical field with the task of studying, inter alia, "the legal situation of the mentally ill from the point of view of private law in the light of Recommendation 818 (1977) of the Assembly".

66. The Committee of Ministers at their 301st Meeting at Deputy level decided to create the proposed Committee of Experts and asked it to study the problems of:

67. (a) The legal situation of the mentally ill from the point of view of private law, in the light of Recommendation 818 (1977) of the Assembly;

(b) The protection of patients' rights;

(c) The compensation for damage caused by medical acts, with a view to identification of specific issues lending themselves to legislative harmonization at European level.

68. Also, the Secretariat of the Council of Europe has prepared document CJ-ME (79) 1 which refers to the following main issues of the subject under study:

(a) The problem

69. Although in medical terms mental illness is just an "illness" among others and must be treated in conformity with the data of modern medical science, in certain cases the treatment of patients having this type of illness creates a number of extra-medical, particularly legal problems. In fact, as this illness affects behaviour

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24/ See the reply of the Council of Europe, submitted on 11 February 1981, in the annex to the present document.

24a/ See Recommendation 818 (1977) of the Parliamentary Assembly of the Council of Europe (Doc. 4014). Report of the Committee on Social and Health Questions. The text of the recommendation was adopted by the Assembly on 8 October 1977.

and the capacity of making a sound judgement people suffering from it may create danger to their own life and security as well as those of other persons. In order to avoid such dangers certain restrictions on the freedom of these patients are admitted in all member States and some private law disabilities may also follow from this illness.

70. Therefore, the legal situation of mentally-ill persons may be studied under two fundamental aspects:

(i) Restrictions imposed on the freedom of mentally-ill persons;

(ii) Civil disabilities of the mentally ill.

71. However, before examining in detail these legal implications the question should be asked whether a legal definition of "mental illness" exists in the legislations of the member States and whether it would be necessary for the purpose of harmonizing laws at European level.

(b) What is mental illness?

72. No legislation, as far as the Secretariat knows, contains a legal definition of mental illness for the purpose of private law.

73. This is first of all a question of medical science and it is very difficult to give it a precise legal definition because as medical science progresses every day the contents and extent of such a definition may change. It is therefore generally thought undesirable to give a definition of mental illness in a legislative text. However, despite the absence of a legal definition, the legislator may exclude certain mental disorders from the notion of "mental illness" if it wishes that some particular provisions on the mentally ill should not apply to the categories of persons suffering from such disorders. For instance alcohol and drug dependence as well as sexual deviations may be excluded from the field of application of legislation on the treatment of mentally sick persons (these disorders are proposed not to be considered as mental illnesses in the Bill presented to the United Kingdom Parliament in 1978 for the Review of the Mental Health Act, 1959).

74. It is also generally accepted that an abnormal behaviour in morals and law alone can never as such be considered as mental illness. However if such behaviours constitute at the same time a mental abnormality then they may be considered as "mental illnesses" not because of the immoral or illegal character but because they are considered as mental illnesses by medical science.

(c) The legal situation of the mentally ill

Restrictions to freedom

75. Such restrictions are usually enforced by internment of the patient in a specialized medical establishment and aimed at protecting the patient himself and other persons from any danger to life or security which the patient's abnormal behaviour may cause. It goes without saying that the competent persons to judge such necessity are always the medical authorities who make their determination in accordance with the actual medical science but the legislations often require the participation or supervision of a judicial or administrative authority to such grave decision which results in substantial restrictions of someone's freedom.

76. A brief examination of legislations in a number of member States of the Council of Europe 25/ shows that whatever system of internment procedure they prefer - judicial, administrative, mixed or purely medical - they all require, without exception, specialized medical opinion as to the necessity of internment. Without such an opinion, judicial or administrative authorities are powerless to commit someone into a medical establishment for mental illness.

77. Accordingly, the internment of a patient for mental illness being just a medical measure in order to protect the patient's life and security as well as the life and security of other persons, no considerations other than those strictly medical (political, moral, religious non-conformism of a person, etc.) should be taken into account in a decision of internment.

78. Moreover the measures of internment should be limited to those which are necessary to protect the patient's life and security as well as that of other persons. This internment being solely a medical measure should be strictly limited to that medical necessity. Therefore the patient should enjoy full freedom to correspond with his family and other persons without censorship unless his medical condition presents a danger of his writing injurious or calumnious letters.

(d) Is compulsory treatment necessary and admissible?

79. The universally accepted general rule for all sick persons is both examination of the patient for diagnosis as well as curative treatment for his illness depending upon the patient's explicit consent.

80. However, since a mental illness reduces or even sometimes suppresses the patient's capacity to judge and take decisions, the physicians may have difficulties in obtaining the patient's consent for a certain treatment or such consent, even if given, would have no legal value because of the mental state of the patient.

(e) What should be the right period of internment of a mentally sick person?

81. The period of internment depends absolutely upon evolution of the illness of the patient and diminution or not of the danger he presents to his life and security and that of other persons. It goes without saying that only medical authorities are in a position to judge these facts. 26/

82. The participation of administrative or judicial authorities or both is admitted here as an additional guarantee but the authorities act upon medical advice on the necessity to prolong or not the internment and as to the initial procedure of internment, no other reasons than purely medical necessities can be admitted to prolong or continue the internment of the mentally ill.

25/ For example, Austria, Denmark, Federal Republic of Germany, Switzerland, United Kingdom.

26/ However, a number of legislations, for example Austria, several German Länder, the United Kingdom, require that the decision of internment be made for a limited period of time and if there is a reason to prolong it at its end a re-examination must be made. Other legislations allow decisions of internment for an indefinite period (e.g. Belgium) but termination of it may be asked from competent authorities at any time if the reasons of internment no longer exist.

(f) Can the mentally-ill person object to his internment or appeal against any decision comporting it?

83. Internment is a very serious measure for the patient because it affects and restricts several of his freedoms. Although any decision of internment is taken upon medical advice in all member States, it is not impossible that medical authorities may fail in their judgement and diagnosis, thus reaching erroneous conclusions. Therefore it would be wise and human to give the patient full rights to object and appeal against any decision of internment even if the patient cannot be considered to enjoy full legal capacity or is already in guardianship. It is not always prudent to give the exercise of these rights to the legal representative because at times for various reasons this person may not be totally impartial in demanding internment or continuation of it.

84. For these reasons several legislations give the patient the right to object or appeal against a proposal or decision of internment, without making reference to his legal capacity. 27/ In other legislations which make no reference to the patient it is not impossible that the judge, on the patient's request, may order a re-examination to the control authorities.

85. The patient while he may be given the right by legislation to object to a decision of internment and if necessary demand its re-examination should also have the right to be heard before the competent authority.

(g) Procedural guarantees for the mentally-ill person before the Court of Human Rights

86. The problem of the procedural guarantees for the mentally-ill person has been raised before the Court of Human Rights. The following cases show the position taken by the above-mentioned Court.

87. The first case originates in an application against the Netherlands lodged with the European Commission of Human Rights in December 1972 by Mr. Frits Winterwerp, a Netherlands national. In 1968, at the request of his wife, Mr. Winterwerp was committed to a mental hospital under a provisional order made by the local District Court. Subsequently, the detention order was renewed periodically by decision of the regional court on the basis of medical reports from the doctor in charge of his case.

88. Mr. Winterwerp complains that he was never heard by the various courts, that he was never notified of the orders concerning his detention, that he did not receive any legal assistance and that he had no opportunity of challenging the medical reports. In his view, his deprivation of liberty cannot be considered "lawful" within the meaning of article 5, para. 1, of the European Convention on Human Rights. He further claims that he was unable to take court proceedings in accordance with article 5, para. 4, to test the lawfulness of his detention. Finally, he alleges a breach of article 6, para. 1, in that his detention deprived him, automatically and without a proper judicial procedure, of the capacity to administer his property. 28/

27/ For example the legislations of Austria, Belgium, Denmark, Norway, Sweden, Switzerland and United Kingdom.

28/ See the judgement of Winterwerp case of the European Court of Human Rights in the Document of the Council of Europe, Strasbourg, 24 October 1979, No. 117403, pp. 1-25.

89. The second case of X v. the United Kingdom was referred to the Court by the European Commission of Human Rights. The case originated in an application against the United Kingdom of Great Britain and Northern Ireland lodged with the Commission on 14 July 1974 under article 25 of the Convention by a United Kingdom citizen, referred to as X in this judgement, Contrary to the usual practice, the identify of the applicant, who died in 1979, has not been made public in view of the wish expressed by his next of kin.

As to the facts

90. The applicant, a United Kingdom citizen born in 1934, died in 1979. At the time of lodging his application with the Commission he was detained in Broadmoor Hospital, a special secure mental hospital for the criminally insane. His complaints were directed against his recall to Broadmoor Hospital in April 1974, following a three-year period of conditional discharge. He claimed that his recall was unjustified, that he was not promptly given sufficient reasons for his re-detention, and that he had no effective way of challenging the authorities' action.

Proceedings before the Commission

91. On 14 July 1974, the applicant lodged his application with the Commission. He complained that he had been recalled to Broadmoor Hospital after three years of normal life, without first going before any legal authority and without any doctors having certified first that he was of unsound mind. He further complained that the habeas corpus proceedings did not fully investigate the merits of the decision to recall him, but merely examined if the recall had been ordered in accordance with the relevant provisions of the 1959 Act. He relied on article 3 and article 5, paras. 1, 2 and 4 of the Convention. On 11 March 1976, the Commission declared the application inadmissible in so far as the applicant alleged inhuman or degrading treatment in breach of article 3. By decision of 14 May 1977, it accepted the remainder of the application.

92. On 23 January 1979, the applicant's legal representative notified the Commission of his client's death, but added that the deceased's sister had informed him on behalf of herself and other members of the family, including X's parents, that they wished the case to proceed. In view of these wishes and the issues of general interest raised, the Commission decided on 1 March 1979 to retain the application. Although the next of kin are today to be regarded as having the status of "applicants" (see the Deweer judgement of 27 February 1980, Series A No. 35, pp. 19-20, para. 37), for the sake of convenience the present judgement will continue to refer to X as the "applicant".

93. In its report of 16 July 1980 (article 31 of the Convention), the Commission expressed the opinion:

> By 14 votes to 2, that X's recall to Broadmoor Hospital and further detention there had not violated his rights under article 5, para. 1;
>
> Unanimously, that there had been breach of article 5, para. 2, in that X was not given prompt and sufficient reasons for his arrest and readmission to Broadmoor;
>
> Unanimously, that article 5, para. 4 had been violated, since X had not been entitled to take proceedings by which the lawfulness of his detention consequent upon his recall to hospital could be decided speedily by a court.

Final submissions to the court

94. At the hearing on 22 June 1981, the Government maintained the submissions set out in their memorial, whereby they requested the Court

"(1) With regard to article 5, para. 1

To decide and declare that on the facts found, the actions taken by the United Kingdom Government recalling the applicant to Broadmoor Hospital and the further compulsory detention of the applicant at the Hospital, constitute a deprivation of liberty compatible with article 5, para. 1 of the Convention.

(2) With regard to article 5, para. 2

(a) To decide and declare:

(i) That article 5, para. 2 of the Convention has no application to the re-detention of a person who is taken back into custody in the circumstances in which the applicant was recalled to Broadmoor in the present case; alternatively

(ii) That in the circumstances that obtained in the applicant's case he was in fact given sufficient information to comply with the requirements of article 5, para. 2 of the Convention.

Alternatively

(b) To conclude that the introduction of the revised procedures now in operation for informing patients of the reasons for their re-detention makes it unnecessary for the Court to pursue the issues to which submissions (a)(i) and (ii) relate.

(3) With regard to article 5, para. 4

(i) To decide and declare that having regard to the applicant's conviction and committal to Broadmoor Hospital by a court in November 1968, article 5, para. 4 of the Convention did not entitle the applicant to have the lawfulness of his detention reviewed by a court on his being recalled to the Hospital;

Alternatively, if the request at (i) should be rejected, then

(ii) To decide and declare that the remedy of habeas corpus satisfied the applicant's entitlement to have the lawfulness of his detention reviewed subsequent to his being recalled to the Hospital."

95. At the hearing, the Commission's Delegate requested the Court

"To determine the questions that have been put before [it] - that is to say whether the applicant was a victim of a violation of article 5, para. 1 and 5, para. 2 of the Convention when he was recalled to Broadmoor Hospital on 5 April 1974 and whether thereafter the applicant was entitled to and received an adequate judicial determination of the lawfulness of his renewed detention in accordance with article 5, para. 4 of the Convention."

As to the law

The alleged breach of article 5, paragraph 1

96. The applicant claimed that his recall to Broadmoor Hospital gave rise to a deprivation of liberty contrary to article 5, para. 1, which, in so far as relevant for the present case, reads as follows:

> "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> (a) the lawful detention of a person after conviction by a competent court;
>
> ...
>
> (e) the lawful detention ... of persons of unsound mind ...;
>
> ..."

97. The relevant facts are not disputed. On 7 November 1968, following X's conviction for an offence of wounding with intent to cause grievous bodily harm, the Sheffield Assizes made an order committing him for an indefinite period to Broadmoor Hospital, a secure mental hospital for the criminally insane; on 19 May 1971, the Home Secretary ordered his conditional discharge; on 5 April 1974, he was recalled to Broadmoor Hospital by warrant of the Home Secretary; X remained confined there until February 1976 when he was allowed out of hospital on leave; he was conditionally discharged a second time on 28 July 1976 and died on 17 January 1979.

A. Whether paragraph 1 (a) and paragraph 1 (e) were applicable

98. Before the Commission, the Government argued that at all times throughout his detention the applicant was lawfully detained after conviction by a competent court within the meaning of paragraph 1 (a) of article 5. In the Commission's opinion, on the contrary, paragraph 1 (e) applies to the exclusion of paragraph 1 (a) whenever the case of an accused person of unsound mind is disposed of by committal to a mental hospital for treatment rather than by imposition of a penal sanction.

99. In the Court's view, there was, in the full sense of the term, a "conviction" - that is to say, a finding of guilt (see the Guzzardi judgement of 6 November 1980, Series A, No. 39, p. 37, para. 100) - "by a competent court" and, following and dependent upon that conviction, a "lawful detention" ordered by the same court. Subparagraph (a) therefore applies. However, the court did not deal with X by way of punishment but, being satisfied that he was suffering from a mental disorder warranting his confinement in a mental hospital for treatment, committed him to Broadmoor. Consequently, subparagraph (e), in so far as it relates to the detention of "persons of unsound mind", also applies. It accordingly follows that, initially at least, the applicant's deprivation of liberty fell within the ambit of both subparagraphs.

100. Having regard to the reasons for X's recall to hospital in 1974 and subsequent detention there until 1976, subparagraph (e) likewise covers the second stage of his deprivation of liberty. The particular circumstances of this case, and notably the fact that X was conditionally released and enjoyed a lengthy period of liberty before being re-detained, may give rise to some doubts as to the continued applicability of subparagraph (a). The Court does not judge it necessary to decide the point, however, since it must in any event verify whether the requirements of subparagraph (e) were fulfilled and no problem arises in the present case as regards compliance with the requirements of subp ragraph (a).

B. Compliance with article 5, para. 1

101. In its Winterwerp judgement of 24 October 1979, the Court stated three minimum conditions which have to be satisfied in order for there to be "the lawful detention of a person of unsound mind" within the meaning of article 5, para. 1 (e): except in emergency cases, the individual concerned must be reliably shown to be of unsound mind, that is to say, a true mental disorder must be established before a competent authority on the basis of objective medical expertise; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder (Series A, No. 33, p. 18, para. 39).

102. The applicant's counsel argued that the recall procedures established under section 66 of the 1959 Act, since they do not lay down any minimum conditions comparable to those stated in the Winterwerp judgement, and in particular the need for objective medical evidence, were incompatible with article 5, para. 1 (e). The unfettered discretion vested in the Home Secretary meant, so it was submitted, that any recall decision, even one taken in good faith, must by its very nature be arbitrary.

Section 66, para. 3 is, it is true, framed in very wide terms; the Home Secretary may at any time recall to hospital a "restricted patient" who has been conditionally discharged. Nevertheless, it is apparent from other sections in the Act that the Home Secretary's discretionary power under section 66, para. 3 is not unlimited. Section 147, para. 1 defines a "patient" as "a person suffering or appearing to be suffering from a mental disorder" and section 4, para. 1 defines "mental disorder" as "mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of mind". According to the Government, it is implicit in section 66, para. 3 that unless the Home Secretary on the medical evidence available to him decides that the candidate for recall falls within this statutory definition, no power of recall can arise.

103. Certainly, the domestic law itself must be in conformity with the Convention, including the general principles expressed or implied therein (see, mutatis mutandis, the above-mentioned Winterwerp judgement, p. 19, para. 45). However, section 66, para. 3, it should not be forgotten, is concerned with the recall, perhaps in circumstances when some danger is apprehended, of patients whose discharge from hospital has been restricted for the protection of the public (section 65, para. 1 of the 1959 Act - see paragraph 11 above). The Winterwerp judgement expressly identified "emergency cases" as constituting an exception to the principle that the individual concerned should not be deprived of his liberty "unless he has been reliably shown to be of 'unsound mind'" (ibid., p. 18, para. 39); neither can it be inferred from the Winterwerp judgement that the "objective medical expertise" must in all conceivable cases be obtained before rather than after confinement of a person on the ground of unsoundness of mind. Clearly, where a provision of domestic law is designed, amongst other things, to authorize emergency confinement of persons capable of presenting a danger to others, it would be impracticable to require thorough medical examination prior to any arrest or detention. A wide discretion must in the nature of things be enjoyed by the national authority empowered to order such emergency confinements. In the Court's view, the terms of section 66, para. 3, read in their context, do not grant an arbitrary power to the Home Secretary; nor are they such that they exclude observance in individual cases of the principles stated in the Winterwerp judgement (see, mutatis mutandis, the Ireland v. the United Kingdom judgement of 18 January 1978, Series A, No. 25, p. 91, para. 240).

Having regard to the foregoing considerations, the conditions under the 1959 Act governing the recall to hospital of restricted patients do not appear to be incompatible with the meaning under the Convention of the expression "the lawful detention of persons of unsound mind". What remains to be determined is whether the manner in which section 66, para. 3 was in fact applied in relation to X gave rise to a breach of article 5, para. 1 (e).

104. It is not disputed that the applicant's deprivation of liberty was effected "in accordance with a procedure prescribed by law" and that throughout it was "lawful" in the sense of being in conformity with the relevant domestic law (see paragraph 89 of the Commission's report). However, it was submitted on behalf of the applicant that his deprivation of liberty was arbitrary and unlawful, and thus not justified under article 5, para. 1 (e), because he had not been "reliably" shown to be of unsound mind by objective medical evidence existing at the time of his recall.

105. The object and purpose of article 5, para. 1 is precisely to ensure that no one should be deprived of his liberty in an arbitrary fashion; consequently, quite apart from conformity with domestic law, "no detention that is arbitrary can ever be regarded as 'lawful'" (see the above-mentioned Winterwerp judgement, pp.16 and 18, paras. 37 and 39). Three minimum conditions required for "the lawful detention of a person of unsound mind" are set out above. Whilst the Court undoubtedly has the jurisdiction to verify the fulfilment of these conditions in a given case, the logic of the system of safeguard established by the Convention places limits on the scope of this control; since the national authorities are better placed to evaluate the evidence adduced before them, they are to be recognized as having a certain discretion in the matter and the Court's task is limited to reviewing under the Convention the decisions they have taken (see the above-mentioned Winterwerp judgement).

106. The applicant was a man with a history of psychiatric troubles. He was first committed to Broadmoor Hospital after his conviction for an offence involving a violent attack on a workmate. His discharge was made conditional upon, inter alia, his being subject to medical supervision at a psychiatric out-patients' clinic. The consultant psychiatrist who treated him during the period of his conditional discharge considered him to be "a querulous suspicious person liable to paranoid ideation [who] inevitably presents a risk to the community"; in a letter written in 1971 to the Sheffield probation service, the consultant psychiatrist spoke of the need to "steer [X] clear of depressed situations which could lead to murder or serious bodily harm to other people". Lastly, X's wife visited the probation officer and told him that, contrary to what she had stated earlier, her husband remaind deluded and threatening.

The reaction of the authorities must be seen against this background (set out at paragraphs 20, 21, 23 and 28 above). On being informed of the wife's complaints, the responsible medical officer at Broadmoor, who had copies of the psychiatric reports prepared concerning the applicant during the period of his conditional release, became alarmed at the possibility of a recurrence of violent behaviour by the applicant, especially if he came to know of his wife's intention to leave him. The responsible medical officer therefore referred the matter to the Home Office and, acting on the doctor's advice, the Home Secretary issued a warrant in pursuance of which the applicant was recalled to hospital the same day, without prior medical examination or verification of the wife's allegations.

107. Regard must also be had to the over-all system under the 1959 Act governing the discharge and recall of restricted patients. Under section 65, para. 1, a court may direct that a hospital order against an offender be made subject to restrictions in respect of discharge only where it appears necessary for the protection of the public. When the Home Secretary, pursuant to section 66, para. 2, discharges a patient from hospital while a restriction order is in force (see paragraph 12 above), he is thus suspending a measure taken to protect the public. As was stated by one of the Divisional Court judges at the hearing on 21 June 1974 in the habeas corpus proceedings brought by X, very often the only way patients of this kind can be allowed back into the community is by releasing them on licence, with very careful supervision and an immediate reaction in the event of a sign of new danger.

In such circumstances, the interests of the protection of the public prevail over the individual's right to liberty to the extent of justifying an emergency confinement in the absence of the usual guarantees implied in paragraph 1 (e) of article 5. On the facts of the present case, there was sufficient reason for the Home Secretary to have considered that the applicant's continued liberty consituted a danger to the public, and in particular to his wife.

108. While these considerations were enough to justify X's recall as an emergency measure and for a short duration, his further detention in hospital until February 1976 must, for its part, satisfy the minimum conditions described above. These conditions were satisfied in the case of X: having examined X after his readmission to Broadmoor, the responsible medical officer was of the opinion that he should be further detained for treatment. This opinion was maintained until December 1975 when an improvement in his condition was noted; up till then the medical reports indicated that he continued in a psychotic state. Like the Commission, the Court has no reason to doubt the objectivity and reliability of this medical judgement.

109. In conclusion, there was no breach of article 5, para. 1.

The alleged breach of article 5, paragraph 4

110. It was argued on behalf of the applicant that he had had no possibility of having the lawfulness of his readmission to Broadmoor judicially determined as required by article 5, para. 4 which provides:

> "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

111. The Court would recall that by virtue of the two orders made against him in November 1968 by the Sheffield Assizes following his conviction for a criminal offence, X was transferred from the authority of the courts to the authority of the Home Secretary and committed to a psychiatric hospital for an indefinite period. After releasing him in May 1971, the Home Secretary ordered his return to hospital in April 1974. This was an administrative decision based, in part, on circumstances distinct from those prompting the initial court orders. Furthermore, although the conditions specified under sections 60, para. 1 and 65, para. 1 of the 1959 Act for the making of such orders depend upon matters, notably medical, which of their nature may change with the passage of time, there was no system of periodic judicial review to verify that these conditions remained satisfied throughout the contested detention.

112. Therefore, without underestimating the undoubted value of the safeguards thereby provided, the Court does not find that the other machinery adverted to by the Government serves to remedy the inadequacy, for the purposes of article 5, para. 4, of the habeus corpus proceedings.

113. In conclusion, there has been a breach of article 5, para. 4.

The alleged breach of article 5, paragraph 2

114. The applicant complained that he had not been adequately and promptly informed of the reasons for his recall to hospital, either by the police when he was taken into custody or, subsequently, by the responsible medical staff at Broadmoor. He claimed to be a victim of a breach of article 5, para. 2 which provides:

> "Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him."

115. The Government invited the Court to have regard to the revised procedure in the matter now in operation and to conclude that it is no longer necessary to pursue the question whether the superseded procedure did or did not comply with article 5, para. 2.

The changes relied on by the Government were introduced expressly "in order to meet criticisms made by the European Commission of Human Rights" on the basis, precisely, of article 5, para. 2. Nevertheless, they date from the end of 1980, are valid only for the future and clearly could not have restored the right claimed by X under article 5, para. 2 whose requirements, moreover, the Government continue to deny having contravened (see the above-mentioned Deweer judgement, and the Luedicke, Belkacem and Koç judgement of 28 November 1978, Series A, No. 29, p. 15, para. 36). It is therefore not possible to speak of a "solution", even partial, "of the matter" (see, mutatis mutandis, Rule 47, para. 2 of the Rules of Court and the above-mentioned Guzzardi judgement).

116. The Government contended that the term "arrested" in article 5, para. 2 is not appropriate to describe the conditions under which a restricted patient may be recalled to a hospital. In their submission, the words "of the reasons for his arrest and of any charge against him" suggest that this provision refers to arrest for a criminal charge. The Commission disagreed with this interpretation which, it pointed out, would have the effect of limiting the protection of paragraph 2 to arrests coming under paragraph 1 (c).

Not only did the respective arguments advanced differ as to the applicability of paragraph 2 to X's situation, but they were also in conflict as to whether it had been complied with in the circumstances. In the Government's view, the reasons given to the applicant and subsequently to his solicitors were sufficient to satisfy any obligation arising by virtue of article 5, para. 2. The Commission, on the other hand, was unanimous in concluding that whatever may have been said to X himself, there could have been no justification for withholding from his solicitors an official and detailed explanation; the vague statement from the Home Office could not constitute the information necessary to make effective use of the right ensured by article 5, para. 4.

117. The Court does not consider that it has to settle this double conflict of opinion, especially since the facts of the case are not entirely clear on the points in issue. The Court would point out in the first place that the need for the applicant to be apprised of the reasons for his recall necessarily followed in any event from paragraph 4 of article 5: anyone entitled - as X was - to take proceedings to have the lawfulness of his detention speedily decided cannot make effective use of that right unless he is promptly and adequately informed of the facts and legal authority relied on to deprive him of his liberty. The Court further notes that at the close of the first hearing before the Divisional Court, the application for a writ of habeas corpus was adjourned because the Divisional Court itself felt that more information was required before any decision could be arrived at. At the adjourned hearing on 21 June 1974, since the detention was apparently legal, the onus was effectively on X to show that the Home Secretary had acted unlawfully in exercising his statutory discretion. However, it is clear from the evidence that lack of information as to the specific reasons for the recall, a matter almost exclusively within the knowledge of the Home Secretary, prevented X's counsel, and thus the Divisional Court, from going deeper into the question. Consequently, the complaint under paragraph 2 amounts, in the particular circumstances, to no more than one aspect of the complaint that the Court has already considered in relation to paragraph 4; there is no call to rule on the merits of a particular issue which is part of and absorbed by a wider issue (see, mutatis mutandis, the above-mentioned Deweer judgement and the Dudgeon judgement of 22 October 1981, Series A, No. 45, para. 69).

The application of article 50

118. Counsel on behalf of X stated that, should the Court find a violation of the Convention, they would be submitting a claim under article 50 for just satisfaction to obtain both compensation for damage suffered and reform of the law. The Government, for their part, reserved their position.

Accordingly, although it was raised under Rule 47 bis of the Rules of Court, the question is not yet ready for decision. The Court is therefore obliged to reserve the matter and to fix the further procedure, taking due account of the possibility of an agreement between the respondent State and the applicant's next of kin.

119. For these reasons, the court

1. Holds unanimously that there has been no breach of article 5, para. 1 of the Convention;

2. Holds unanimously that there has been a breach of article 5, para. 4;

3. Holds by 6 votes to 1 that it is not necessary also to examine the case under article 5, para. 2;

4. Holds unanimously that the question of the application of article 50 is not ready for decision;

   (a) accordingly reserves the whole of the said question;

   (b) invites the Commission to submit to the Court, within two months from the delivery of the present judgement, the Commission's

written observations on the said question and, in particular, to notify the Court of any friendly settlement at which the Government and the applicant's next of kin may have arrived;

(c) reserves the further procedure and delegates to the President of the Chamber power to fix the same if need be.

120. In this connection the following was the dissenting opinion of Judge Evrigenis: "To my great regret I have been unable to agree with the majority of the Chamber as regards point No. 3 of the operative provisions of the judgement. The right of an individual deprived of his liberty to be informed promptly, pursuant to paragraph 2 of article 5, 22/ of the reasons for his being taken into custody constitutes a safeguard of personal liberty whose importance in any democratic system founded on the rule of law cannot be underestimated. Quite apart from enabling the person detained to make proper preparations for bringing legal proceedings in accordance with paragraph 4 of article 5, it is the embodiment of a kind of legitimate confidence or expectation (confiance légitime) in the relations between the individual and the public powers. In other words, what is guaranteed is a right that is autonomous and not auxiliary to the one provided for under paragraph 4 of article 5. The merits of the complaint under paragraph 2 of article 5 should therefore be examined."

Organization of American States

121. The Organization of American States commended the work of the Sub-Commission and the Rapporteur and made the following, inter alia, brief comments and suggestions:

(a) A suggestion not to use terms as "suffering from", "afflicted with" or other such terms which reflect negative attitudes; but instead of them use the terms "persons diagnosed as having mental illness" or persons "with" or "having" mental illness as possible alternatives and

(b) A suggestion that adequate differentiation be made between persons diagnosed as having mental illness and persons diagnosed as having mental retardation or other related neurological disabilities. This because there is often systematic confusion with mental disabilities resulting in misapplication of services, treatment and resources.

22/ Paragraph 2 of article 5 of the European Convention for the Protection of Human Rights and fundamental freedoms reads: "Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for the arrest and of any charge against him". See European Convention on Human Rights, Collected Texts, Council of Europe, Eleventh Edition, August 1976, pp. 101-115.

Activities of non-governmental organizations concerning the protection of human rights of persons diagnosed as mentally ill or mental disorder and the abolition of psychiatry

122. Eighteen non-governmental organizations 30/ and two national organizations, the Association for Mental Health (MIND of London, England) and the Comité National Suisse de la Santé Mentale, have transmitted very useful information concerning their activities in the field of the protection of human rights of persons diagnosed as mentally ill or suffering from mental disorder, including their treatment in psychiatric hospitals, and the abolition of psychiatric abuse and terror. Likewise they have made important comments and suggestions related to the questionnaire of the present study and the draft body of guidelines, principles and guarantees, prepared by the Rapporteur.

123. In particular, the contribution made by the Association of Penal Law and the International Commission of Jurists, which provided the proceedings of two meetings of experts held at the International Institute of Higher Studies in Criminal Sciences at Siracusa under the auspices of the two above-mentioned non-governmental organizations was remarkable. 31/

124. Amnesty International expressed its particular concern about one aspect of the main problem; that is the forcible confinement as well as the treatment in psychiatric hospitals of people for the exercise of their human rights rather than for authentic medical reasons. Also, Amnesty International underlines the abuse of psychiatry for political purposes and presents concrete complaints concerning the treatment of prisoners of conscience and other persons inside psychiatric hospitals in some countries. The following complaints are common to the very many accounts of conditions in these psychiatric hospitals by former prisoners of conscience:

> Most prisoners of conscience, and very many other inmates, in such institutions have been mistreated with drugs. The drugs which have most often been applied are haloperidol, aminazin and triftazin. These drugs, which are used commonly for treatment of certain types of mental illness in many countries, have been administered routinely in psychiatric hospitals in this country in excessive doses, without necessary precautions and without regard as to whether they were positively dangerous for the subject. Application of these drugs in many known cases caused much suffering to those receiving them.
>
> The drugs have also frequently been administered in excessive doses as a form of punishment. Other psychiatric methods which have been used against inmates of psychiatric hospitals in this country as a form of punishment are the drug sulfazin, insulin shock therapy and various methods of fixation or immobilization.
>
> Many inmates have been beaten, often severely. This form of ill-treatment has been especially common in special psychiatric hospitals, where it has been common practice to employ convicted prisoners as orderlies.
>
> Prisoners of conscience have been put under pressure to renounce their convictions and the public expression of their convictions as a pre-condition for release.

30/ See their names in the introduction to this report, p.7.

31/ In this connection see the Preface by Ch. Bassiouni, and the Introduction and Commentary of the Draft Guidelines by N. MacDermot and I. Khan, as well as the Draft Guidelines for the Protection of Persons Suffering from Mental Disorder, in the booklet The Protection of Persons Suffering from Mental Disorder, (Nouvelles Etudes Pénales, Association Internationale de droit pénal, Editions Eres, Toulouse, France) 1981, pp.5-6, 10-11 and 28.

125. In another country Amnesty International knows of over 30 cases of persons who have been detained or reported to have been detained in psychiatric hospitals during the past four years, because of the non-violent exercise of their human rights. All the information received by Amnesty International indicates that these individuals were neither mentally unfit at the time of confinement nor a danger to themselves or others. Examples which have come to the notice of Amnesty International during the past year include a leading member of a Free Trade Union Movement and cases of persons assigned to a psychiatric hospital after going on a hunger strike in support of their demands to be allowed to emigrate. Former prisoners of conscience interned in psychiatric hospitals have alleged that they were forcibly subjected to treatment with drugs, electro-shock treatment, beatings by medical assistants, and reduced food rations.

Furthermore the same non-governmental organization refers to certain countries in which persons have been arrested and forcibly sent to psychiatric institutions for the non-violent exercise of their human rights rather than for authentic medical reasons. Among the examples mentioned are the following two: in 1976, a group of Orthodox religious believers in a city organised a religious seminar to discuss religious and philosophical matters. Of at least eight persons who have been arrested since then in connection with the seminar, four were confined to psychiatric hospitals, and two were sent to a psychiatric institution for diagnosis. Also in 1976, a group of workers got together to protest collectively at violations of their labour rights. By early 1978, no less than five of the group's leading members had been confined to psychiatric hospitals.

125(a). The World Medical Association is, among others, referring to the contemporary trends, myths and facts of mental illness. The philosophico-politico-mystical movements of the 1960s had an effect both on medicine and on psychiatry, which is more exposed than any other branch of medicine to the winds of social change. The youthful enthusiasm being unaware of the specific problems of the psychiatric patient and the economic and social realities of rehabilitation, it has gone so far as to deny the existence of mental illness in order to pursue the myth of the complete elimination of psychiatric hospitals. Beneath this watchwords and theories seem to lie the signs of a real power struggle which indicate that our society has not yet assimilated certain new branches of knowledge. The World Medical Association further raised the problem of the confusion between treatment and punishment, doctor and judge, it notes the contemporary tendency to create what are in effect small courts of patients so committed before which doctors and patients are brought to confront one another; and asks the question whether it is not simpler to let the doctor be responsible for patient's treatment and, if necessary, to call in for a second opinion another specialist who alone has competence in the matter.

126. The Federation internationale des droits de l'homme, and the World Federation of Neurology have dealt, inter alia, with the protection of the rights of in-patients. In particular the latter organization has transmitted information related to admission and commitment procedures for psychiatric patients in Norway.

127. The task of the Citizen's Commission on Human Rights (hereinafter called CCHR), is to achieve reform in the field of mental health and the preservation of the rights of individuals under the Universal Declaration of Human Rights. The

CCHR has been responsible for many great reforms. At least 30 Bills over the world have been prevented by CCHR, which would otherwise have inhibited even more the rights of mental patients, or would have given psychiatry the power to commit minority groups and individuals against their will. The CCHR has been instrumental in securing the release from mental hospitals of patients who were held there against their will. It has brought about public awareness of the existence of the many abuses in the psychiatric field, including LSD (and other) experiments carried out on patients without their consent. It has exposed unsanitary conditions and illegal activities in mental hospitals, which were then corrected by health and hospital corporations. All over the world, branches of CCHR offer help to members of parliaments to increase their awareness of the mental health situations, so that actual reform can occur. The CCHR made the following basic suggestions in connection with the subject under study:

(a) Governments should start immediately to investigate psychiatry and the mental health field and get the real facts;

(b) The CCHR and others should provide Governments with workable methods to handle the mentally ill;

(c) An amnesty should be granted to all psychiatrists who admit to having engaged in abusive practices and human rights violations and who have ceased to do so;

(d) All community health centres and other mental care homes should be run by churches or other religious groups who have a real care for patients and a workable method;

(e) The use of all drugs, whether street drugs or psychopharmaca drugs should be discontinued.

The conclusion of the CCHR is that "There will be peace on earth when the mental health field has been reformed and is clean". Further the CCHR has transmitted useful documentation reflecting the position of certain participants in the International Conference on Psychiatry against Human Rights held in Zürich - Oerlikon, on 27-28 June 1981. At that Conference experts in the fields of institutionalizing, psychiatric practices and alternative healing methods expressed their views. 32/

128. The New Life Psychiatric Rehabilitation Association of Hong Kong, among others, refers to the three major areas of rehabilitation of patients: occupational, residential and social. Voluntary agencies like the New Life Rehabilitation Association play a major role in the local running of rehabilitative services in the community, with the Government supplying most of the material resources.

129. The World Federation for Mental Health, which has its Head Office in Canada, has submitted useful information and abstracts from provincial mental health legislation and proposals from the President of the Canadian Mental Health Association regarding relevant amendments to the Canadian Human Rights Act which, when properly adopted by the competent legislative bodies, will clearly prohibit discrimination on the basis of "mental disorder".

32/ See, in this connection, the relevant lecture by Professor Dr.Thomas Szasz, unprinted, in the file with the secretariat of the Centre for Human Rights.

Reaction of world public opinion to psychiatric abuse, and the protection of persons diagnosed as suffering from mental illness or mental disorder

The Declaration of Hawaii

130. The topic of psychiatric ethics received considerable attention at the Sixth World Congress of Psychiatry. 33/ The General Assembly of this Congress adopted a statement on ethical standards in psychiatric practice called "The Declaration of Hawaii".

131. Because of the importance of this topic and its close relationship with the subject under study, the main principles of this Declaration are presented below: 34/

(a) Ever since the dawn of culture ethics has been an essential part of the healing art. Conflicting loyalties for physicians in contemporary society, the delicate nature of the therapist-patient relationship, and the possibility of abuses of psychiatric concepts, knowledge and technology in actions contrary to the laws of humanity, all make high ethical standards more necessary than ever for those practising the art and science of psychiatry.

(b) As a practitioner of medicine and a member of society, the psychiatrist has to consider the ethical implications specific to psychiatry as well as the ethical demands on all physicians and the societal duties of every man and woman.

(c) The aim of psychiatry is to promote health and personal autonomy and growth. To the best of his or her ability, consistent with accepted scientific and ethical principles, the psychiatrist shall serve the best interests of the patient and be also concerned for the common good and a just allocation of health resources. To fulfil these aims requires continuous research and continual education of health care personnel, patients and the public.

(d) Every patient must be offered the best therapy available and be treated with the solicitude and respect due to the dignity of all human beings and to their autonomy over their own lives and health.

The psychiatrist is responsible for treatment given by the staff members and owes them qualified supervision and education. Whenever there is a need, or whenever a reasonable request is forthcoming from the patient, the psychiatrist should seek the help or the opinion of a more experienced colleague.

33/ This Congress was held in Honolulu, Hawaii, from 30 August to 5 September 1977. See Comparative Medicine East and West, Vol. VI, No.1, 1978, pp.79-81.

34/ The full text of the "Declaration of Hawaii" is contained in the Comparative Medicine East and West, pp.80-81.

(e) A therapeutic relationship between patient and psychiatrist is founded on mutual agreement. It requires trust, confidentiality, openness, co-operation and mutual responsibility. Such a relationship may not be possible to establish with some severely ill patients. In that case, as in the treatment of children contact should be established with a person close to the patient and acceptable for him or her.

If and when a relationship is established for purposes other than therapeutic, such as in forensic psychiatry, its nature must be thoroughly explained to the person concerned.

(f) No procedure must be performed or treatment given against or independent of a patient's own will, unless the patient lacks capacity to express his or her own wishes or, owing to psychiatric illness, cannot see what is in his or her best interest or, for the same reason, is a severe threat to others.

In these cases compulsory treatment may or should be given, provided that it is done in the patient's best interests and over a reasonable period of time, a retroactive informed consent can be presumed and, whenever possible, consent has been obtained from someone close to the patient.

(g) The psychiatrist must never use the possibilities of the profession for maltreatment of individuals or groups, and should be concerned never to let inappropriate personal desires, feelings or prejudices interfere with the treatment.

The psychiatrist must not participate in compulsory psychiatric treatment in the absence of psychiatric illness. If the patient or some third party demands actions contrary to scientific or ethical principles the psychiatrist must refuse to co-operate.

(h) To increase and propagate psychiatric knowledge and skill requires participation of the patients. Informed consent must, however, be obtained before presenting a patient to a class and, if possible, also when a case history is published, and all reasonable measures be taken to preserve the anonymity and to safeguard the personal reputation of the subject.

For children and other patients who cannot themselves give informed consent this should be obtained from someone close to them.

(i) Every patient or research subject is free to withdraw for any reason at any time from any voluntary treatment and from any teaching or research programme in which he or she participates. This withdrawal, as well as any refusal to enter a programme, must never influence the psychiatrist's efforts to help the patient or subject.

The psychiatrist should stop all therapeutic, teaching or research programmes that may evolve contrary to the principles of this Declaration.

The Ciba Foundation Symposium on Medical Care of Prisoners and Detainees

132. Lawyers, psychiatrists, doctors and prison administrators from North America, Europe and North Africa participated in the above-mentioned Symposium and discussed, inter alia, how legislation affecting the physical or mental health of people held in

prisons and camps might be implemented and improved. Also, other topics like the management of disturbed or violent offenders, experiments on prisoners, tension in camps, medical psychiatric survey in Alabama State Prison, the interaction between prisoners, victims and other social networks were considered. 35/

The International Union of Judges

133. The International Union of Judges, during its meeting in Vienna in 1981, paid particular attention to the protection of the interests of mentally handicapped persons in private law. 36/ This Union deals mainly with issues relating to the voluntary and involuntary admission to hospital of a patient, committal proceedings, safeguards, etc.

International literature and press articles concerning basic issues of mental illness, the abolition of psychiatry and the protection of human rights of patients

134. Important books have been published on the above-mentioned issues, describing their complexity and interdependence and urging States, Governments, regional organizations, the competent bodies of the United Nations and specialized agencies, to take appropriate legal, medical, economic, social, administrative, cultural and environmental measures and to make an effective contribution to the promotion and protection of the human rights of thousands of individuals all over the world whose rights and fundamental freedoms have been grossly and systematically violated on the grounds of mental illness or mental disorder. 37/

135. Other non-governmental organizations, leagues and associations have proposed the establishment of advocacy systems for the representation of mentally disabled individuals. In adversary or judicial proceedings, the importance of counsel to represent not only the mentally disabled client (or those acting on his or her behalf) but also the State or provider against which a claim is made should be recognized. Other organizations have analysed certain aspects of the subject matter and have inter alia, stated that liberal progressives over the past century have urged that the courts treat the mentally ill as patients rather than criminals. 38/ In particular, the United States Helsinki Watch Committee, which seeks to monitor domestic and international compliance with the human rights provisions of the Helsinki Final Act, has published a specific article on Mental Health in the United States. 39/

35/ See the Report on Medical Care of Prisoners and Detainees, Ciba Foundation Symposium 16 (new series), (Elseviez, Excerpta Medica, North Holland, 1973), pp.1-230.

36/ A copy of the general report of the meeting of the Union of Judges can be found in the file of the secretariat of the Centre for Human Rights.

37/ See Thomas Szasz, (a) Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man (New York, A Doubleday Anchor Original, 1969), pp.1-245, and (b) Psychiatric Slavery - When Confinement and Coercion Masquerade as Cure, (New York and London, The Free Press, A Division of Macmillan Publishing Co., Inc., 1977), pp. 1-139. Also, B.J. Enis and R.D. Emery, The Rights of Mental Patients, (New York, Avon Books, 1978) and M. Kindred, J. Cohen, D. Penrod, Th. Shafer, The Mentally Retarded Citizen and the Law, (New York, The Free Press, A Division of Macmillan Publ. Co., Inc.).

38/ See A.A. Stone in "Helsinki Watch - A Helsinki Record", Mental Health in the United States, October 1980, p.1.

39/ See L.A. Carty, in "Helsinki Watch", pp. 1-16.

136. Relevant also is the article published in a daily newspaper 40/ under the title "Technological progress bears perils for human beings". Another newspaper has referred to a case in which the psychiatric confinement occurred nine years after the events. 41/ Furthermore, another newspaper in an article entitled "U.S. High Court Weakens Law on Mentally Retarded", 42/ indicates that the United States Supreme Court has ruled that a federal "Bill of Rights" for the mentally retarded, enacted by Congress six years ago, did not oblige states to provide any particular level of care or training for retarded people in state institutions. In connection with this point, writing for the majority, one judge disagreed and said: "The law simply does not create substantive rights" but "does no more than express a congressional preference for certain kinds of treatment". Furthermore, in an article published in another newspaper 43/ under the title: "Helping the mentally disabled to thrive", an appeal was addressed to help by all means mentally handicapped persons because, among others, they are actually homeless persons: "There has to be someone who will create a place the handicapped will consider home". In the same newspaper an editorial comment was published under the title: "Who cares for the mentally ill?". It mentioned among others that:

> "New York state and city officials will attempt today to settle yet another clash in their protracted struggle over the care of the mentally ill. The dispute arose when a state official arranged surprise inspections of city hospital psychiatric wings, then ordered them to relieve overcrowding, perhaps by using empty beds in other wards.
>
> Highhanded, says the city's hospital administration, blaming the crush of mental patients on the state's policy of 'deinstitutionalization'. They note that 60,000 patients have been released from large upstate mental hospitals in the last 16 years, without commensurate subsidy to the city to which most of them went to live. Instead of dipping into scarce funds to staff their new psychiatric wards, city officials want the state to declare a crowding emergency and take more patients into state hospitals."

The antipsychiatric movement

137. This movement, which is supported by many lawyers, doctors, psychiatrists, psychologists, sociologists, and others has particularly referred to the involuntary

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40/ See "Kathimerini" published in Athens, Greece, on 28 September 1979.

41/ See "Au Tribunal correctionnel de Tours - Une affaire d'internement psychiatrique jugée neuf ans après les faits", in Le Monde, 18 mars 1982.

42/ See International Herald Tribune, 22 April, 1981.

43/ The New York Times, 21 October, 1981, p.C.21.

procedures provided for patients. The most radical abolitionist aspect this movement proposed is that there ought to be no such legal procedures at all. 44/

138. The following are the most important arguments put forward by the "antipsychiatry" movement on the issue of involuntary admission:

(a) Since there does not exist in reality "mental illness", involuntary admission and detention are by definition unjustifiable;

(b) The involuntary admission and detention of the mentally ill is not genuine therapy but in fact a form of social control. In this connection it should be noted that some States abuse their power, in particular, for political reasons and purposes by asking some psychiatrists to act as gaolers rather than as physicians;

(c) In certain cases the diagnosis of mental illness or mental disorder is inaccurate with the principal consequence that involuntary admission and detention are arbitrary;

(d) The so-called argument of dangerous to self or to others or to the community is in many cases false and invalid.

138(a). Another disturbing letter was received from a country of the Far East. The following main information is contained in this letter:

"Did you know that 300,000 patients are hospitalized in mental hospitals and the number of beds are increasing by 5,000 every year?

Did you know that almost all of them are compulsorily detained into mental hospitals?

Did you know that many of them are deprived of freedom of communication, and that it is very difficult for them to ask lawyers to take the proceedings for their liberation?

Did you know that patients are deprived of their right to the proceedings that are guaranteed by section 4 of article 9 of the International Covenant on Civil and Political Rights?"

44/ One of the spokesmen of the "antipsychiatry movement" is the Australian psychologist, Professor R. Winkler. He has been mainly involved in "pseudo-patient" studies. See R. Winkler "Research into Mental Health Practice Using Pseudo-Patients" in Medical Journal of Australia, 1974, 2, 399. Another supporter of the objectives of the "antipsychiatry movement" is the American psychiatrist Thomas Szasz. See his books: The Myth of Mental Illness, (New York, Perennial Library, Harper and Row, 1974), pp.1-250, 1961. In connection with his attitudes and views on the subject of "mental illness" see in particular J. Lardner's article "Dissident Psychiatrist", in International Herald Tribune, 1 June 1982. In this article Szasz wrote: "... I look upon this [mentally illness] as slavery. I don't believe that in a free society anybody should be deprived of his liberty on any ground other than accusation, trial and being found guilty of a criminal charge - a view that has prevailed with many a judge and jury in recent years ...". The arguments put forward by Th. Szasz are strongly supported, among others, by the Association for the Abolition of Involuntary Mental Hospitalization, (a United States non-governmental organization).

In this connection it should be also mentioned that some of the leaders of the American psychiatric establishment have defended themselves against Szasz's attacks. Miles F. Shore, Professor of Psychiatry at Harvard University says about Szasz: "He is a practising psychiatrist who has a point of view which he expressed vividly and with great force. Any live field which is dealing with serious issues has people with a variety of points of view. In this country [USA], they have a right to be heard, to be evaluated and to help keep peoples thinking straight". See J. Lardner, in International Herald Tribune, 1 June, 1982.

Conclusions

139. The following main conclusions have been drawn from the research and the study undertaken on human rights and scientific and technological developments - guidelines, principles and guarantees for the protection of persons detained on the grounds of mentally ill-health or suffering from mental disorder:

A. That in order to discuss the protection of persons diagnosed as mentally ill, it is useful to clarify first of all what is mental illness and the communities in which this question can reasonably be asked. Thus the question would be irrelevant in:

(i) A community in which there is a strong village culture and where there are no mental hospitals as we know them; 45/

(ii) A community based on a social system where family problems are dealt with in the family;

(iii) A community which does not recognize mental illness; and

(iv) A community whose understanding of mental illness is different from that of the overwhelming majority of communities.

140. In this connection, it should be clarified that the research undertaken shows that there have been and still are communities without any of the kinds of mental conditions or behaviour which are referred to in this study as "mental illness".

B. That the meanings of the concepts of "mental illness", "mentally ill" and "mental disorder" have not been standardized.

141. One of the basic conclusions drawn from the comparative survey undertaken, mainly from the replies received from Governments, specialized agencies, regional organizations and non-governmental organizations, is that, no legislative uniformity or harmonization exists in connection with the definition or the meaning of the concepts "mental illness", or "mentally ill".

142. The majority of national laws or statutes do not contain any specific definition of the concepts of "mental illness" or "mentally ill". 46/ However, some national laws or statutes do use the concepts of "mental disorder" or "psychopathic disorder" or "psychiatric disorder" or "psychical illness" or "mental patient", "mental impairment", "insane person" or "mental disease" or "mental defect", "subnormality", "severe subnormality" and "psychopathy", "mental's emotional disturbances" and contain a definition or give the meaning of these concepts. 47/

45/ For example, mental hospitals do not exist in Mauritius even today. See the reply of the Government of Mauritius dated 14 July 1981 in the annex to the present report.

46/ See e.g., in the annex to the present report, the summary of the replies of the Governments of Afghanistan, Belgium, Bulgaria, Canada (province of Saskatchewan), Chile, Costa Rica, Cyprus, Denmark, Dominican Republic, Greece, Italy, Kuwait, Niger, Portugal, Senegal, Sweden, Syrian Arab Republic, Spain, Upper Volta.

47/ See e.g. in the annex to the present report the summary of the replies of the Governments of Australia, Bahamas, Barbados, Bulgaria, Canada (from the statutes of the provinces of Alberta, British Columbia, Manitoba, New Brunswick, New Foundland, Nova Scotia, Ontario, Prince Edward Island and Saskatchewan), Cyprus, Finland, France, Germany, Federal Republic of, Greece, Italy, Japan, Korea, Kuwait, New Zealand, Philippines, South Africa, Sweden, Thailand, United Kingdom, United States.

143. Although very few national laws contain precise definitions of the concepts "mental illness" or "mental disorder" or "mental weakness", these concepts have nonetheless been sufficiently clarified by science and jurisdiction. 48/ Thus, it was realized already at an early stage that persons suffering from mental disorder or mental weakness generally belong to the group of the handicapped and consequently require the particular care of the State.

144. The law of very few States setting the boundary between "mental illness", which in clinical practice means "psychosis" and "other mental disorder" defined mental illness according to university teachings on psychiatry and based it on the classification of diseases adopted by the World Health Organization in 1967. 49/

145. The definition of "mental illness" or "mental disorder" is difficult, since criteria change with time and from place to place, and since a whole new range of psychological disturbances have emerged, linked with working pressure, tension, environmental conditions, including pollution, and the socio-economic pattern of modern life. 50/

146. However, for the purpose of this study the meaning of "mental illness" will be the following:

"Any psychiatric or other illness which substantially impairs mental health".

147. Also for the purpose of this study a mentally-ill person means a person who, owing to mental illness, requires care, treatment or control for his own protection, or the protection of others or the protection of the community and for the time being is incapable of managing himself or his affairs.

148. Further the term "mental disorder" is taken to mean arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind.

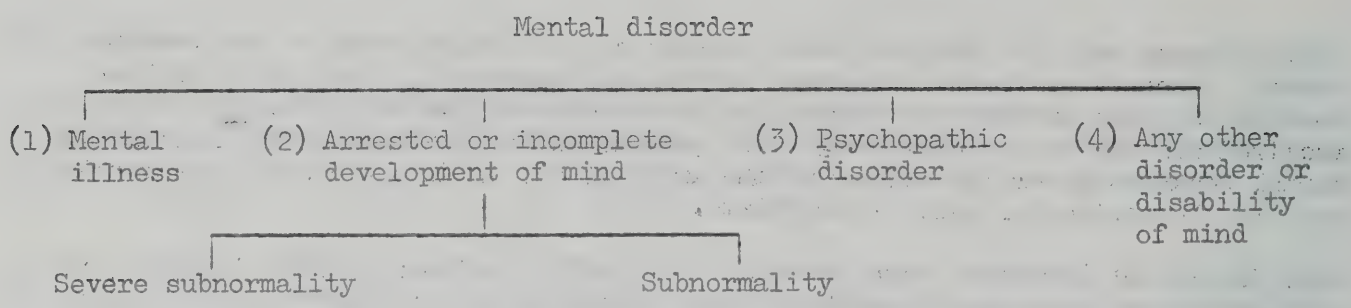
149. The following plan reflects the position of the definition of the concept of "mental disorder" and the meaning of the concepts of "severe subnormality", "subnormality", "psychopathic disorder", which are contained in some common law countries, including the United Kingdom. 51/

48/ See, e.g. in the annex to the present report the summary of the replies of the Governments of Austria and the Syrian Arab Republic and the non-governmental organization, the International Human Rights Law Group.

49/ See e.g. the summary of the reply of the Government of Finland in the annex to the present report.

50/ See Recommendation 818 (1977) on the situation of the mentally ill, Parliamentary Assembly Council of Europe, Doc. 4014 report of the Committee on Social and Health Questions.

51/ In this connection , see in the annex to the present report the replies of the Government of the United Kingdom and of the non-governmental organization "Mind".



C. Mental Hospitals

150. The conditions and the experiences of mentally ill persons vary from mental hospital to mental hospital.

151. Some limitations are in certain cases intentionally imposed on the freedom of the mentally ill by hospital staff as punishment or therapy.

152. Often limitations on personal freedom of the patients are imposed for the convenience of staff and for more efficient operation of the mental hospital.

153. The life of a mentally-ill person in a mental hospital is in many cases regulated by extensive, usually unwritten, rules that are enforced, for the most part, not by professional but by non-professional staff. When a patient is accused of breaking these unwritten rules he is punished, sometimes severely. Also the ward staff in some cases will write in its records that the patient was "aggressive" or "violent", etc.

154. One of the most serious problems in mental hospitals is the overcrowding of patients, which often leads to unsatisfactory living conditions, lack of privacy, poor food services, defective administration, bad relationships between the patient on the one hand and doctors and nurses on the other and inadequacy of treatment standards in general.

155. It should be stated that modifications to the laws of certain States for the protection of the legal and human rights of the mentally ill or of persons suffering from mental disorder, will be in effect negated if the whole mental health care system is inadequately financed or if a proper relationship is not maintained between central institutions, community care centres and institutions such as nursing homes.

D. Treatment and Consent

156. Only the legislation of a small number of States provides clearly the extent to which treatment may be imposed without consent 52/ on involuntarily detained mentally ill persons or on persons suffering from mental disorder.

52/ In connection with informed consent see the following information submitted by Cyprus: "Fully informed consent of the mental patient should be the basis of all mental health intervention and generally without it such an intervention cannot morally be justified and in some cases (psychotherapy, behaviour therapy) their success is to some extent contingent on informed consent. The only exception would be in the case of a patient judged incompetent preferably by a court or a tribunal. The right of a patient to informed consent should include the kind of treatment the mental health personnel may or may not carry out. It can be said that such a right is the cornerstone or the basis of the moral relationship underlying the patient-clinicians contracts for treatment" (E/CN.4/Sub.2/446 of 15 July 1980). Also, see L.O. Gostin "Consent to Unusually Hazardous, Unestablished or Irreversible Treatment in Psychiatry ..." in The Protection of Persons Suffering from Mental Disorder, (Nouvelles Etudes Pénales, Association Internationale de Droit Pénal) pp. 73-86.

157. Technical therapeutic procedures entailing permanent lesion (e.g. lobotomy) should be prohibited.

158. Also, for mental patients, enforced treatment causes concerns even beyond those for the individual's right to privacy, because certain treatment techniques, such as psychosurgery, including lobotomy, 53/ and electro-convulsive therapy (ECT), remain experimental in nature and present real dangers to the patient.

159. Psychotropic drugs have serious and often irreversible side effects. It is exactly these types and methods of treatment for which advocates have sought to establish the protections and safeguards characterized as "the right to refuse treatment".

160. The legislation of very few States prohibits expressis verbis psychiatric abuses.

Procedures for admission to mental hospitals

161. Almost all legislations provide for procedures for the admission and discharge of voluntary patients to mental hospitals on the grounds of mental illness or mental disorder.

162. The legislation of very few States requires ipso jure that there should be a judicial review or an appeal of involuntary admission once it has occurred.

163. All legislations provide certain procedures for the involuntary admission 54/ of patients to mental hospitals on the grounds of mental illness or mental disorder. These procedures vary in the various political and legal systems.

164. A great number of legislations requires a complete judicial hearing as a prerequisite to involuntary admission.

165. Under a great number of legislations involuntary admission may be and often is initiated by two medical practitioners; however under a smaller number of legislations involuntary admission could be based on one medical report.

166. Many legislations provide that a decision to admit a person to a mental hospital as an involuntary patient shall be taken only by a competent court or a competent mental health tribunal.

167. It is necessary to consider the differences between mental illness and most other diseases. Mental illness strikes at an individual's ability to make rational judgements in the conduct of his life. Normally, when a person experiences a physical disease, he is aware that he is ill and seeks appropriate help. Often this is not the case with mentally ill persons, who do not recognize their disturbance and its effect upon their ability to function. Hence involuntary institutional care may be needed.

53/ E.A. Balayan, Legal Aspects of Psychiatry in the Soviet Legislation, p. 16.

54/ By the involuntary admission and detention of a patient many of his rights collectively can be violated, e.g. the right to liberty, freedom of movement and residence, the right to work, etc. (articles 3, 13 and 23 of the Universal Declaration of Human Rights and articles 9, 12 of the International Covenant on Civil and Political Rights and 6 of the International Covenant on Economic, Social and Cultural Rights).

168. Involuntary commitment to a mental institution subjects the person to loss of liberty. Many of the problems relating to commitment procedures stem from the necessity of reconciling the needs for protective measures and for reasonable adequate procedural safeguards. 55/

169. Commitment proceedings are very different in the several countries. The following legal systems, afford greater or lesser safeguards to the patient.

170. Commitment may be sometimes requested by the patient himself, more frequently by his relatives or friends, by physicians, administrative authorities or by the public prosecutor. In some countries (Belgium, for example) a great power of initiative is given to the guardian of a patient. Some laws, for instance, those of Japan, Switzerland, Luxembourg seem to identify the interest of the patient with the behaviour of his family; other laws consider the interest of a mentally ill person objectively, in a quite independent way.

171. The opinion of one or several doctors is generally heard before commitment; it may be expressed in a certificate or recommendation (for example South Australia, Sweden, Denmark, Ireland), and also in the form of an expert judgement (Switzerland, Liechtenstein); sometimes there may be a previous examination in the same hospital (Finland).

172. Commitment may be ordered by the Director or Superintendent of a mental hospital (Japan, Finland, Denmark, Norway), but more frequently it will be for the local or central administrative authority to provide therefore (Government, prefect, mayor, town council: for example Italy, France, Switzerland, Liechtenstein, Japan, Ivory Coast).

173. The opinion of an expert body composed of doctors, lawyers and sometimes laymen is often heard in this procedure.

174. In Greece, a commission of doctors has the power to order commitment in certain cases; in other countries the patient or his family are entitled to appeal to a technical review commission from the commitment order given by another authority: (Sweden, Ireland, Norway). Such commissions are composed of doctors, lawyers and sometimes laymen.

175. Some laws try to ensure a fair debate in the administrative proceeding (for example, Switzerland and Liechtenstein).

176. Most legal systems limit the period of time a person may be held and fix specific rules for periodic re-examination of the case (Italy, Germany, Netherlands, Sweden, Finland) and possible extension of committal (Australia and Ireland).

177. In Greece and Morocco the prosecutor may order commitment of dangerous patients on the basis of medical examination.

178. Most reliable are the systems which afford the patient judicial protection: this means that a full and fair debate is generally ensured.

55/ See also the report on Human Rights and Scientific and Technological Developments by the Secretary-General (E/CN.4/Sub.2/446 of 15 July 1980), pp. 5-29. On the question of the human rights of persons subjected to any form of detention or imprisonment, see the Report of the Working Group on that subject (E/CN.4/Sub.2/1982/34).

179. In some cases a judge is called to control all commitment orders (Italy, Luxembourg).

180. In other countries a Court is enabled to order commitment directly, after a complete debate, including sometimes an expert judgement (Germany, Netherlands, Senegal), or after hearing the opinion of a technical commission (Portugal).

181. In Scotland the Sheriff (District Judge) is called to approve the recommendations of two doctors. In Western Australia and Victoria a patient may be referred to a hospital by a Justice of the Peace as well as by a medical practitioner.

182. At last, many countries permit an appeal to the courts from a committal issued by administrative authorities (Italy, Switzerland), or from a refusal of discharge issued by the director of a hospital or by a technical review board (Italy, Australia, Belgium, Netherlands, Luxembourg, Norway, Denmark).

183. Several safeguards are offered to a mentally-ill person in the various systems. Some of them have combined a certain number of devices to ensure the maximum respect of liberty in the commitment procedure.

184. In addition to the formal commitment procedures some States authorize summary commitments. The difference between formal procedure and summary procedure is clear only in some legal systems (for example in Norway, Japan, Greece, Portugal, Scotland). In Ireland the difference is slight, since a police officer may take a fool into custody directly and ask a doctor for a recommendation of commitment.

185. Generally in such urgent cases a certificate of a health officer will be sufficient when immediate hospitalization is deemed necessary. In Liechtenstein urgent committal is adopted to prepare a medical report in view of the formal procedure. A similar proceeding exists in Japan; it is based on the consent of the patient's relatives.

186. After a short period the patient must be released, unless a formal commitment order has been obtained in the interval. In Switzerland the administrative Board of Guardianships can order urgent commitment without a previous expert report. The law does not fix an automatic expiry and leaves to the concerned patient the initiative of an appeal to the Courts.

187. The Swiss Cantons can authorize physicians to order urgent commitment of mentally ill persons.

188. Sometimes in urgent cases commitment is decided by a different authority. For instance, in Germany and Senegal an administrative authority (instead of the local Court) can order urgent commitment, to prepare an expert report, or for dangerous patients; but the decision is subject to immediate control of the Judiciary. In the Netherlands commitment is ordered by the Mayor in such cases, on the basis of a medical certificate; according to the normal procedure the Courts would be competent. In Belgium urgent commitment can be ordered only by Communal authorities, even before the issue of a medical certificate.

189. In France urgent commitment of dangerous patients can be ordered by the Prefect without medical examination, the same happens in Tunisia, where the Mayor provides.

190. The law does not establish any term for a subsequent examination or for automatic discharge.

191. In the Rapporteur's view if the mental health care system as a whole is characterized by neglect and confusion, if the financing is inadequate and administration weak, then even the most clearly and perfectly adopted legislative and administrative measures for the protection of the human and legal rights of the mentally ill will be irrelevant.

II. DRAFT BODY OF GUIDELINES, PRINCIPLES AND GUARANTEES FOR THE PROTECTION OF THE MENTALLY ILL OR PERSONS SUFFERING FROM MENTAL DISORDER 56/

I. Preliminary observations

192. Scientific and technological developments provide ever-increasing opportunities to better the conditions of life of peoples and nations in a number of instances, but they can give rise to social problems as well as threaten the human rights and fundamental freedoms of the individual.

193. Improved medical and psychotherapeutic technology can in some cases constitute a threat to the physical and psychic integrity of the individual.

194. There are reports that scientific and technological products, means and methods have already been misused in many member States of the international community in a disturbing number of cases, in particular in the treatment of persons detained on grounds of mental ill-health or mental disorder.

195. Mental health law proceedings are of cardinal importance in terms of the freedom of the patient who ought to be entitled to protect his human and legal rights by every means.

196. The following guidelines, principles and guarantees are not intended to cover every legal, medical, economic and social aspect related to the patient's admission to an institution, detention, treatment, discharge and rehabilitation in the community. Also, in view of the great variety of legal, medical, social, economic and geographical conditions of the world community, it is obvious that not all of the guidelines, principles and guarantees are capable of immediate application in all countries at all times. This applies particularly to some of the least developed countries, where matters related to mental health are acute and important but where other urgent health problems in the fields of nutrition, infectious diseases and sanitation absorb the greater part of the anyhow limited resources available for the national health plan.

197. Thus, these guidelines, principles and guarantees are intended to serve as a guide to Governments, specialized agencies, national, regional and international organizations, competent non-governmental organizations and individuals, to stimulate a constant endeavour to overcome economic and other practical difficulties in the way of their adoption and application, since they represent, as a whole, minimum United Nations standards for the protection, in general, of the human and legal rights of the mentally ill and of persons suffering from mental disorder.

II. General guidelines and principles

198. All States shall adopt, if necessary, new legislative and administrative measures and provide the appropriate means in order to:

(a) Seek new ways of humanizing the care of the patient by observing the humanitarian elements and the quality of care and treatment, as opposed to sophisticated technology, and by reconsidering in this context the appropriateness, the conditions and control of utilization of certain therapies which may leave permanent brain damage or change the personality of the patient;

56/ In this body of guidelines the term "patient" covers the terms "the mentally ill" and "persons suffering from mental disorder".

(b) Provide care in a human physical and psychological environment, qualified medical staff in sufficient numbers and an individualized treatment plan for every patient;

(c) Establish and provide special services for minor patients, who have special needs;

(d) Encourage and instruct local authorities and communitiies to be more involved in the socio-professional rehabilitation of ex-patients and their integration as far as possible in normal life, by creating selective placement programmes, workshops and accommodation, and in particular, by setting up information programmes aimed at changing attitudes towards those who are, or were, patients;

(e) Ensure that the registers kept in mental hospitals and other psychiatric institutions on an ex-patient, or any other relevant documentation on his case, shall be considered as a strict medical professional secret which cannot be used in such a way as to constitute a stigma or a handicap for an ex-patient;

(f) Prohibit the abuse of psychiatry for political purposes or other non-medical grounds.

III. Specific guidelines, principles, procedures and guarantees

Application

Article 1

These guidelines, principles and procedures shall be applied impartially.

Article 2

1. There shall be no discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

2. A background of treatment or hospitalization of any patient in the past shall not justify any discrimination at the present.

Definitions

Article 3

For the purpose of this body of guidelines, principles, procedures and guarantees, the concepts of:

(a) "mental illness" means "any psychiatric or other illness which substantially impairs mental health";

(b) "mentally ill" means a person who, owing to mental illness, requires care, treatment or some control for his own benefit or with a view to the protection of other persons or of the community and for the time being is incapable of managing himself or his affairs; and

(c) "mental disorder" means arrested or incomplete development of mind, psychopatic disorder and any other disorder or disability of the mind".

Basic rights and fundamental freedoms of the patient

Article 4

1. Every patient shall be treated with humanity and respect for the inherent dignity of the human person.

2. Every patient, save as hereinafter provided, shall enjoy the same human rights and fundamental freedoms as his fellow citizens.

3. Every patient shall, in particular, have the right to protection from exploitation, abuse and degrading treatment.

4. There shall be a definite time-limit on the permissible period of conditional status of a patient. After that time he shall be treated as his fellow citizens.

Article 5

1. A diagnosis that a person is a patient shall be determined in accordance with internationally accepted medical standards.

2. Difficulties of adaptation to certain moral, social, cultural or political values or religious beliefs shall not be a determining factor in diagnosing a mental illness or a mental disorder.

Article 6

1. Every patient shall be treated and cared for, as far as possible, in the community in which he lives.

2. Whenever possible a patient shall be treated in a mental hospital 57/ near his home or the home of his relatives or friends.

3. Community-based facilities shall assist in satisfying basic everyday needs as well as providing medical, nursing and rehabilitation services.

Article 7

1. Every patient shall be entitled to the best care and treatment in accordance with the highest attainable standards of physical and mental health.

2. Every patient shall have a legal right to receive whatever social and medical services and assistance are necessary to protect him from any harm, including chemical intrusions, abuse by other patients and staff or acts causing mental distress.

3. These rights shall be guaranteed by the national Constitution.

Article 8

1. A mental hospital in which patients can be treated shall have access to:

(a) Adequate and regular supplies of medication;

(b) Diagnostic and therapeutic equipment for the patient;

57/ In this body of guidelines the term "mental hospital" covers the terms "care centre" and "psychiatric hospital", but not the term "nursing centre".

(c) Qualified medical and nursing staff in sufficient numbers, and adequate space to provide the patient with a programme of appropriate and active therapy and privacy where possible.

2. Mental hospitals shall only accept a certified patient. A patient shall not be certified unless his mental illness or mental disorder has reached a stage where it is obvious to a competent court or mental health tribunal.

3. Every mental hospital shall be inspected by the higher competent authorities at least once every month.

Article 9

1. Every patient shall have the right to the least restrictive alternatives necessary to fulfil the purpose of his treatment.

2. The treatment and care of every patient shall be based on an individually prescribed plan, reviewed regularly, revised as necessary and provided by qualified medical staff.

3. Certain therapies and treatments like psychosurgery and electroconvulsive treatment shall never be applied without the patient's consent or the consent of his legal representative.

4. Psychiatric knowledge and skills shall only be employed for the diagnosis, therapy and rehabilitation of the patient and shall never be absued by being employed for other non-medical purposes.

Article 10

1. Medication shall be given to a patient only for therapeutic purposes and shall not be administered as a punishment or used for the purpose of restraint or for the convenience of the medical and nursing staff.

2. All medication shall be recorded in the patient's records and be prescribed by a qualified medical practitioner or by a qualified member of the nursing staff.

Article 11

1. Every patient shall have the right to refuse treatment.

2. Every patient, as a principle, shall have the right to refuse medication at least for 24 hours before the hearing of his case.

Article 12

Every patient, who has the legal capacity to make decisions about his treatment and life shall have the right to an informed consent. 58/

58/ "Informed consent" is consent obtained freely without threats or improper inducements after appropriate discussion with the patient of matters related to his mental illness, the nature, purpose and duration of the treatment, possible pain and discomfort, possible side-effects and expected benefits of the treatment.

Admission to mental hospital

Article 13

1. A patient shall be admitted to a mental hosptial as a voluntary patient if:

(a) Two qualified medical practitioners consider, after a proper personal examination, that the patient is suffering from mental illness or mental disorder and is likely to benefit from admission for care and treatment;

(b) The patient has been informed of and understands the purpose of admission; and

(c) He requests, consents or does not object to such admission without undue influence or inducement.

Article 14

Every voluntary patient shall have the right to leave the mental hospital at any time unless there are serious grounds for him to be retained as an involuntary patient. In this case all the relevant provisions of article 16 for involuntary patients shall apply.

Article 15

1. No one shall be admitted into a mental hospital for observation for a period exceeding 48 hours; and during that time he shall be examined by the superintendent of the medical hospital or a second medical practitioner.

2. Preventive detention of a patient shall be prohibited.

Involuntary admission

Article 16

1. Involuntary admission is a great infringement of the human rights and fundamental freedoms of the patient, and therefore he shall be admitted to a mental hospital as an involuntary patient only if:

(a) There is a medical recommendation of at least two medical practitioners recommending the admission for care and treatment of the patient on the ground that he is suffering from severe mental illness or mental disorder and he is dangerous to himself, or too dangerous to others or to the community; and

(b) In accordance with a decision taken by a competent court or a competent health tribunal.

2. In an emergency one medical practitioner can admit a patient to a mental hospital and shall immediately inform the administration of the mental hospital and the competent court or the competent mental health tribunal, which shall pronounce its decision in accordance with article 17 and in the shortest possible time.

Article 17

A decision to admit a patient to a mental hospital as an involuntary patient shall be taken only by a competent court or a competent mental health tribunal after an appropriate preparation and proper hearing of the case.

Notice

Article 18

1. A notice a reasonable time in advance of any judicial hearing of the case of the patient shall be required by law.

2. The notice shall be written in a language which the patient understands and shall contain the time and place of the hearing, the name, address of the lawyer who will represent him, the legal and medical standards under which he may be committed, the legal rights which he has prior to the hearing and at the hearing, the grounds and specific facts that are alleged to justify commitment and the names, profession and addresses of all persons who will testify in favour of or against his hospitalization.

Article 19

In the proceedings before the court the patient shall be entitled:

(a) To be represented by a trained lawyer and experienced advocate;

(b) To be heard personally;

(c) To attend and participate in the hearing; this right of the patient shall only be restricted on the ground that the behaviour of the patient in the court so undoubtedly disrupts the proceedings that they cannot continue without his expulsion;

(d) To see any relevant reports and documents submitted to the court, except where, or to the extent that, the court considers it would pose a substantial risk of harm to the patient's health;

(e) To call a free and independent expert witness; and

(f) To request the presence of any other person of his family or any friend.

Main functions of the lawyer

Article 20

The lawyer who appears for a patient in the mental health proceedings shall have the following main functions:

(a) To advise generally the patient of his human and legal rights;

(b) To prepare the case of the patient in accordance with the law and the material relating to the actual facts of the case; in particular to produce or request an independent medical report or any other evidence and to study and evaluate all reports and documents submitted to the court;

(c) To prepare for appearance in other cases before other courts in which the status, or the interests of the patient are discussed;

(d) Generally to constitute a "legal presence" in the court and in the mental hospital promoting an atmosphere of sincere concern for the protection of the human and legal rights of the patient.

Article 21

1. The court shall give its decision in writing, stating its findings and the reasons of its decision.

2. Ratified copies of the decision shall be furnished to the patient, to his lawyer or to his legal representative.

Review and appeal procedures

Article 22

1. The periodic judicial review of the cases of patients shall be provided by the national Constitution.

2. A decision to admit an involuntary patient shall be reviwed at specified reasonable intervals by the court and the patient shall be entitled to be released unless the court is convinced that the requirements in article 16 still apply.

3. The patient shall have the right to apply periodically to the court for his release.

Article 23

The patient, represented by his lawyer or any interested person or assisted by a court appointed lawyer or counsellor, shall have the right to appeal to a higher court against the decision to admit him to a mental hospital as an involuntary patient.

Article 24

1. The law shall provide in any case the maximum permissible duration of involuntary detention and treatment on the grounds of "danger to self", "danger to others", and "protection of the community".

2. The patient or his legal representative or any interested person shall have the same rights of appeal as provided by articles 22 and 23 against a decision to renew his detention in a mental hospital.

The right to communicate

Article 25

1. Every hospital patient shall have the right to communicate with people outside the mental hospital.

2. He shall have the unrestricted right to receive and send uncensored communications or letters from and to his lawyer, or guardian or other legal representative or competent authority, or his family or his friends.

3. He shall have the right to receive visitors regularly, limited only as strictly as necessary in the interest of his health and the protection of himself and the others.

Other basic rights

Article 26

A hospital patient shall further have the following rights limited only, as strictly as necessary, in the interest of his health and the protection of himself and the others:

(a) To practice his religion;

(b) To privacy;

(c) To enjoy facilities for education and vocational training;

(d) To enjoy facilities for reading, recreation and sport; and

(e) To purchase essential items for daily living including clothes, recreation, sport and communication.

Article 27

1. Any patient who has not been by a court declared incapable shall not be treated as if he were incapable only on the ground that he is or has been hospitalized in a mental hospital.

2. Every patient shall have the right to be registered and vote, unless he has been declared by a court incapable to exercise this basic right.

3. Every patient who has not been by a court declared incapable shall have the right to exercise all his civil, political, social or cultural rights including the right to manage his own economic affairs and control the disposition of his assets.

Article 28

1. Forced labour in mental hospitals shall be prohibited.

2. The labour of a patient shall not be exploited to the detriment of his own interests. He shall, as far as possible, be compensated for his labour commensurate with the quantity, quality and value of his work.

3. A patient shall have the right to active occupation suited to his social, cultural and training background and designed to promote his rehabilitation and reintegration into the community.

Guardian

Article 29

Every patient shall have the right to a qualified guardian appointed by a competent court, when this is required to protect the patient's well-being and interests.

Criminal proceedings

Article 30

1. If during the investigation, prosecution, or trial of a criminal matter, a person or his legal representative states that he is a patient or a court has reason to suspect that a suspected or accused person suffers or suffered at the relevant time from mental illness or mental disorder, it should order a proper medical, in particular, psychiatric report and should, if necessary, order the person to be admitted to a mental hospital.

2. Medical and especially psychiatric reports shall, inter alia, deal with all relevant legal issues, such as the ability of the patient to stand trial as well as recommendations on criminal responsibility.

3. A suspected, accused, convicted or detained person shall have the right to an independent psychiatric examination and report, whenever his mental condition is relevant to legal proceedings.

Article 31

Neither criminal charges or criminal conviction shall be a sufficient reason for varying the procedures and standards for determining the presence or absence of mental illness or mental disorder.

Article 32

1. Police, prosecutors, judges, medical practitioners and psychiatrists engaged in criminal investigations or proceedings shall regard with particular caution and responsibility any apparent consents, confessions or acquiescent conduct of suspected or accused patients.

2. No one patient shall be compelled to testify against himself during a criminal proceeding.

Article 33

Prosecuting authorities or judges empowered to institute or approve criminal charges shall have regard, in the light of psychiatric recommendations and reports, to a suspected or accused person's present mental condition, or his mental condition at the time of the commitment of his alleged crime, when deciding whether to prosecute further or whether to allow him to be treated by voluntary or involuntary community-based facilities or mental hospital treatment or care.

Article 34

1. If there is serious reason to suspect that an accused patient is not fit to stand trial because of severe mental illness or mental disorder the court shall inquire into the question, if necessary upon its own authority.

2. In such a case, if the accused patient is found to be incapable, owing to severe mental illness or mental disorder, of understanding the nature or object of the proceedings in general, the proceedings shall be suspended and the court shall declare that the patient is unfit to stand trial.

3. If in the course of criminal proceedings against a patient found not fit to stand trial it can be shown that a material element is lacking in the offence with which he is charged, the court shall by a judgement finally terminate the proceedings in favour of the accused patient.

Article 35

On the basis of the principle nullum crimen sine mens rea a person shall not be held criminally responsible if by reason of severe mental illness or mental disorder he was unable to control or restrain his criminal impulses, or was unable to appreciate the criminal nature of his acts.

Article 36

A condition of mental illness or mental disorder which does not fully eliminate criminal responsibility should be considered as diminishing responsibility and should be taken into consideration by the court in determining the sentence.

Article 37

1. A patient who is acquitted because of failure to establish a material element of the offence with which he is charged, should be admitted to a mental hospital only as a voluntary patient or, following a decision by the court, as an involuntary patient, in accordance with the requirements of article 16.

2. If a person is acquitted by a court on the ground of lack of criminal responsibility due to severe mental illness or mental disorder, but the material facts of a crime are otherwise established against him, the court shall have the power, if he is amenable to care and treatment, to order either community-based treatment or, if the requirements of article 16 apply, treatment in a mental hospital.

Article 38

1. Where a patient is admitted to a mental hospital by order of a court he shall have the same human, legal rights and protections as other involuntary patients.

2. Every patient confined to a mental hospital under the criminal law and proceedings shall have substantially the same appeal and review rights as a patient confined in a mental hospital under civil law proceedings.

Article 39

A convicted prisoner suffering from mental illness or mental disorder shall be provided with adequate mental health care and treatment and shall be transferred from prison to an ordinary mental hospital if adquate mental care and treatment and appropriate special space is not available in the prison.

Article 40

A patient who has been sentenced at the end of his sentence shall be released and shall not be admitted to or retained in a mental hospital as an involuntary patient unless in accordance with the requirements of article 16.

Minor patients

Article 41

Every minor patient shall have the same right to resist hospitalization under the same grounds, standards and procedures as adults.

Article 42

Every minor patient in mental hospitals shall be treated as normally as possible.

Article 43

Every minor patient shall have the right to a public education, regardless of the degree of mental, emotional or physical handicap. In particular, every minor patient shall be individually evaluated and receive, if possible, an individualized educational or training programme.

Article 44

The administration of a mental hospital shall be required at frequent and regular intervals after relevant recommendations and reports by the medical staff, to examine the propriety of hospitalization of each minor patient.

Legal aid

Article 45

A patient who at any time is unable to secure the services of a qualified lawyer shall have the right to such legal aid and advice services, if possible free of charge.

IV. Remedies

Article 46

(a) National level

1. Every patient shall have the right to an effective remedy by a competent court for acts under civil and criminal law, negligence or treatment contrary to the provisions of international instruments on human rights, to the law and medical ethics or to the present guidelines and principles. Such remedies shall be recognized by the Constitution.

2. Professional medical bodies shall investigate any complaint by a patient against a medical practitioner for professional misconduct.

(b) Regional and United Nations level

Every patient or his legal representative shall be entitled to submit any application, petition or communication to the competent regional or United Nations organs or bodies provided by relevant regional or international human rights instruments, in case that the Government or national authorities violate his human rights and fundmaental freedoms or the present guidelines, principles and rights.

V. Implementation

Article 47

States should implement these guidelines and principles through appropriate legislative judicial and administrative measures and means which shall be reviewed periodically.